California Grant Application and Annual Report

for the

Maternal and Child Health Services
Title V Block Grant Program

FFY 2014-2015
(October 1, 2014 – September 30, 2015)

Attachment to the Abridged Document

STATE OF CALIFORNIA

Maternal Child and Adolescent Health Program
Center for Family Health
Department of Public Health

Systems of Care Division
Department of Health Care Services

Preliminary Draft
05/22/14

A. Select Health Systems Capacity Indicators (HSCI)

Health Systems Capacity Indicator 01

The rate of children hospitalized for asthma (International Classification of Diseases (ICD)-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.

Narrative:
HSCI 01 is the rate per 10,000 for asthma hospitalizations among children less than five years old. The rate of children hospitalized for asthma was 22.0 per 10,000 in 2012. Hospitalization rates for asthma were highest among African American children (62.3 per 10,000) compared to Hispanics and Whites (20.8 per 10,000 and 18.1 per 10,000, respectively. Nationally, asthma prevalence increased between 1980 and 2002 for children and adults. Since 2005, California has consistently achieved the Healthy People 2010 objective of 25 hospitalizations per 10,000 children under age 5.

The role of air pollution and second-hand smoke in the severity of asthma attacks is well documented in literature. Unlike second hand smoke which can trigger an asthma attack, the role of air pollution in initiating asthma is still under investigation and may involve a very complex set of interactions between indoor and outdoor environmental conditions and genetic susceptibility. The California's Air Resources Board (ARB) has been a leader in developing and supporting research to understand the relationship between air pollution and asthma. In the Central Valley the ARB F.A.C.E.S. project is examining the role of particulate matter pollution in the exacerbation of childhood asthma.

America's Health Rankings accounted for air pollution as a health determinant in ranking the over-all health of states [31] Since 2003, the annual America's Health Rankings reports listed California with the highest level of air pollution among all states. The U.S. had an average of 1.59 days of ozone levels exceeding 75 parts per billion in 2008; California had an average of 8.45 days. [32] Although air pollution in California dropped significantly over the last decade, about a third of the population live in communities where the air quality does not meet federal health standards.

Based on the 2010 local needs assessments conducted, San Joaquin County expressed concern about air pollution in their region and also of having the greatest asthma burden in adults 18-64 years of age in California. An emerging issue in Fresno County was air pollution and its link to increased asthma especially in young children and in African Americans. The Kern County MCAH System of Care planned to develop **closer working relationships among its community partners to raise the awareness level among partners about health and environmental issues affecting the MCAH population.**

To raise awareness of the links between air quality and health, MCAH, in collaboration with FHOP, released for the first time, data on the annual number of days that ozone levels are above regulatory standard by region and the local rate of smoking in households with children less than five enrolled in CHDP as part of a compilation of local health indicators for the current local needs assessment process underway.

Health Systems Capacity Indicator 02

The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.

Narrative:

Health Systems Capacity Indicator 02 (HSCI-02) is the percent of Medi-Cal enrolled children less than one year of age who received at least one CHDP health assessment in the reporting year.

The Memoranda of Understanding between MCMC plans and local CHDP programs continue. Each local CHDP program coordinates with MCMC plans to develop a procedure for working together. DHCS provides TA and program consultation to local CHDP programs and MCMC plans to resolve problem areas. The CHDP program at the local level provides outreach to providers and children and their families (such as health fairs and other community events). SCD collaborated with the California Medical Home Project and the LA Medical Home Project. LA County CCS also works with LA Care MCMC Plan for better coordination of care by the medical home.

Quarterly meetings between CHDP programs and MCMC plans are occurring in some counties and less frequently in other counties. SCD continues to collaborate with MCMC plans on statewide operational problems that occur with the carve-out of CCS services in Medi-Cal and HF managed care plans.

Local CHDP programs continue to provide education, training and outreach to CHDP provider office staff and the community. The CHDP Gateway pre-enrollment process and infant deeming appear to be having the greatest effect on this performance measure.

California has made a strong commitment to reducing the number of uninsured children and ensuring access to healthcare services for children. MCAH Division programs, such as the AFLP, BIH and CPSP screen and assess children and adolescents for Medi-Cal eligibility and assist them in obtaining services.

SCD continues to collaborate with MCMC management staff on statewide operational issues that affect local CHDP programs, including provider office site visits and sharing of information between program site reviewers in MCMC and CHDP.

To increase access to care, infants born to women eligible for and receiving Medi-Cal at the time of birth are automatically deemed Medi-Cal eligible for one year without a separate Medi-Cal application or SSN. This includes continued Medi-Cal eligibility for infants up to age one, which provides that the infants shall remain eligible, regardless of any increases in the family's income.

Health Systems Capacity Indicator 03

The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

Narrative:

Health Systems Capacity Indicator 03 (HSCI-3) is the percent of Healthy Families (HF) enrollees under one year of age who received at least one CHDP health assessment. HF plans did not conduct CHDP health assessments, but instead covered preventive examinations based on the AAP guidelines. The HF Program relied on HEDIS to evaluate the performance of the health plans. While HEDIS data is available on the MRMIB website, the specific data for HSCI-3 is not collected by MRMIB.

Pursuant to Assembly Bill 1494, the 2012-13 State Budget required the transition of children enrolled in HF to the Medi-Cal Program (except for AIM linked infants and children) and transitioned eligible subscribers to the Medi-Cal Program in four Phases throughout 2013. In November 2013, infants enrolled into the HFP as a result of being born to a mother who was on the AIM program with an income above 250 percent and up to 300 percent of the FPL were transitioned to DHCS and integrated into the new DHCS AIM-Linked Infants Program. As of February 1, 2014, DHCS fully implemented the ALIP health plan. In addition, DHCS has established a monitoring and reporting system to assure its health plans are fulfilling their obligation to provide covered Medi-Cal health services to their members in accordance with State and federal requirements. Infants in the ALIP with CCS-eligible medical conditions will continue to receive case management and care coordination from the CCS Program.

Health Systems Capacity Indicator 06A

The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)

Narrative:

Medi-Cal, California's Medicaid program has been covering low-income Californians since 1966. As of 2013, there were 8.5 million people enrolled. Beginning January 1, 2013, pursuant to Assembly Bill (AB) 1494, (Committee on Budget, Chapter 28, Statutes of 2012), Healthy Families Program (HFP) no longer enrolled new applicants (except for AIM linked infants and children). Through four phases in 2013, all HFP enrollees were transitioned to Medi-Cal, as allowed under federal law. By December 31, 2013, 751,293 children successfully transitioned to Medi-Cal. This transition resulted in 286,679 new cases added to Medi-Cal's new Optional Targeted Low Income Children's Program.

Effective November 1, 2013, 531 HF AIM linked infants above 250% and up to 300% FPL were transitioned into the new DHCS AIM Linked Infants Program (ALIP). The AIM-linked infants, covered under the authority of the Children's Health Insurance Program, will maintain their current income eligibility based on the income standards of their mother for up to their first two

years of life and, if they meet income eligibility requirements for Medi-Cal, they will subsequently be transitioned into the Medi-Cal program. As February 1, 2014, DHCS fully implemented the transition of the ALIP under DHCS, similar to processes when the program was operated by MRMIB.

The state completed the expansion of Medi-Cal managed care services to all of California's 58 counties. Under the Affordable Care Act, Medi-Cal coverage will expand in 2014, making 1 million to 2 million new people eligible. Children who need health coverage but do not qualify for Medi-Cal may be eligible for the state's County Children's Health Initiative Program (C-CHIP). The C-CHIP provides federal funding for low cost health coverage to uninsured children through age 19, who are not eligible for the no-cost Medi-Cal Program, and whose household income falls within 251% to 300% of the federal poverty level (FPL).

Health Systems Capacity Indicator 07B

The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

Narrative:

Health Systems Capacity Indicator 07b (HSCI-7b) is the percent of EPSDT eligible children (CHDP in California) aged 6 through 9 years who received any dental services during the year. The goal of this indicator is to increase dental health services to Medi-Cal eligible children at an important stage of dental development.

Current activities related to this indicator include: The CHDP Gateway covers dental services for pre-enrolled children up to 60 days after a CHDP health assessment and has increased access to dental services. CHDP Gateway offers the opportunity to apply for permanent enrollment in Medi-Cal or HF which includes dental benefits. Most Denti-Cal providers accept the pre-enrollment receipts and many children receive dental services through the Gateway. CHDP Gateway offers the opportunity to apply for permanent enrollment in Medi-Cal which includes dental benefits through Denti-Cal or dental managed care plans. Healthy Families is no longer in existence and therefore not an option. Those children are now eligible for Medi-Cal.

CHDP tools such as the revised two-sided full color "PM 160 Dental Guide" will continue to improve the quality of dental screenings and more acceptable annual referrals to a dentist beginning at age one. A provider notice, under development, will encourage CHDP providers to discuss the importance of dental sealants with families of 6 and 12 year old children. Fluoride varnish applications (3/year) became a benefit of the Medi-Cal program. CHDP providers were informed of this benefit, asked to apply fluoride varnish, and be reimbursed through Medi-Cal. A Power Point dental training has been developed and released on the State CHDP website for CHDP Providers and local program staff which includes resources and oral health topics specific to screening and referring children to a dentist by age one. The main purpose of the training is to encourage appropriate dental referrals using a four category classification system. Providers, as well as CHDP offices, will be able to make emergency and urgent dental referrals sooner, if not

immediately, once trained. A condensed dental training has also been developed and will be placed on the CHDP website shortly. Fluoride varnish applications, 3 per year, became a benefit of the Medi-Cal program for children age 0 to 6. There will soon be a power point fluoride varnish training for CHDP providers to be placed on the CHDP website. The condensed version of the dental training as well as the fluoride varnish power point training are now available on the CHDP website.

Brochures entitled, "Fluoride Varnish-- Helping Smiles Stay Strong" and "Every Child Needs a Dental Home" have been released to local CHDP programs. These can be downloaded from local CHDP websites. They are currently available in three languages with three more languages planned. A resource guide has been developed and distributed to local programs. It includes online links for brochures including most oral health topics for children ages 6 through 20. There is also work on completing online links for ages 0 through 5. The *Fluoride Varnish-Helping Smiles Stay Strong* brochure has been revised and is available in five languages. The *Every Child Needs a Dental Home* brochure has also been revised and is available in four languages. Both brochures are available on the CHDP and MCAH websites. The newly revised Prevent Tooth Decay in Babies and Toddlers brochure is available on the CHDP and MCAH website in four languages. The two Resource Guides for CHDP providers, 0-5 and 6-20, have been revised and placed on the CHDP and MCAH websites.

The State Dental Hygienist Consultant in conjunction with the Oral Health Subcommittee of the CHDP Executive Committee continues dental updates to providers, local program staff, and families. The dental sections of the Health Assessment Guidelines, including anticipatory guidance, are being aligned with Bright Future Oral Health. Changes specific to California are being added. The dental section of the Health Assessment Guidelines is being updated to reflect new oral health issues and information. It will be an interactive Guideline with many links to resources and references.

B. National Performance Measures

Performance Measure 01

The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.

a. Last Year's Accomplishments

In 2012, GDSP detected and confirmed over 850 genetic and congenital abnormalities as a result of its NBS Program. California has effectively achieved universal coverage for NBS for genetic, metabolic and hematological disorders, with nearly 100 percent of newborns screened for all conditions for which screening was mandated.

All the conditions for which the NBS Program screens, including over 40 metabolic disorders, endocrine disorders, and hemoglobinopathies, are CCS-eligible. GDSP and SCD have been

collaborating to ensure that infants identified with abnormal metabolic, endocrine, sickle cell, cystic fibrosis, or severe combined immunodeficiency disorder (SCID) screening results, from the current and expanded testing, receive prompt diagnostic evaluations at one of the CCS-approved Special Care Centers (SCC) in the state. The county CCS programs expedite GDSP referrals, so that infants with suspected illness can be identified and treated promptly in order to maximize prevention of premature death or serious disabilities. The guidelines for diagnostic follow-up and treatment of the over 40 additional metabolic disorders and congenital adrenal hyperplasia are in place.

The pilot study for SCID began in August 2010 and has proved that SCID is far more common than first thought. Prior to the inception of SCID screening in California, the incidence of classical SCID was thought to be 1 in 100,000. Screening nearly 1.2 million newborns (through December 2012), has identified 20 babies with SCID requiring bone marrow transplants (1:60,000) and another 48 babies with immune disorders that required monitoring and/or treatment. The total incidence of SCID and other significant immune disorders is 1 in 17,500.

Pregnant women in California can participate in the California Prenatal Screening Program in several different ways:

1. Patients who only submit a blood specimen in the 2nd trimester (15 to 20 weeks) get Quad Marker Screening [risk assessment made based on 4 analytes: AFP, human chorionic gonadotropin (HCG), uE3, and Inhibin]
2. Patients who submit a blood specimen in the 1st trimester (10 to 13 weeks, 6 days) and another blood specimen in the 2nd trimester (15 to 20 weeks) get Serum Integrated Screening: [risk assessment made based on Pregnancy Associated Plasma Protein and HCG in the first trimester, plus the Quad Marker Screening analytes in the second trimester]
3. Patients who submit both 1st and 2nd trimester specimens as well as have a Nuchal Translucency (NT) Ultrasound measurement taken, get Sequential Integrated Screening [risk assessment made based on all analytes from the Serum Integrated Screening plus the NT measurement].

   Sequential Integrated Screening identifies over 90% of fetuses with Down syndrome. Participation in the California Prenatal Screening Program includes diagnostic follow-up services for those with risks assessments above the cut-off.

b. Current Activities

SCD and GDSP programs work together to address issues as they arise and update policies and reporting forms as needed in an effort to ensure that babies who screen positive receive expedited care at a CCS approved Special Care Center. Although CCS makes a special effort to expedite these cases some slight delays may occur due to the CCS staffing cuts.

CCS provides services for conditions identified on NBS tests, develops standards, and approves Metabolic, Endocrine, Sickle Cell, Cystic Fibrosis, and SCID SCCs for treatment.

c. Plan for the Coming Year
GDSP will continue to screen for genetic and congenital disorders, including testing, follow-up and early diagnosis, in order to prevent adverse outcomes and minimize clinical effects. GDSP ensures the quality of analytical test results and program services by developing standards and quality assurance procedures, and monitoring compliance with them. GDSP fosters informed participation in its programs through a combination of patient, professional, and public education, as well as accurate, up-to-date information and counseling (e.g., Hemoglobin Trait Carrier Follow-up Program, Maternal PKU Program, Gene HELP Resource Center and the Sickle cell Counselor Training and Certification Program).

GDSP will continue to work collaboratively with state and local agencies, including SCD, CCS-approved SCCs, GDSP NBS Contract Liaisons and other NBS Program staff, local County CCS programs, and Area Service Center Project Directors and Medical Consultants to ensure that newborns identified with positive screening reports are quickly evaluated, diagnosed, and appropriately treated, and that families are informed and supported throughout the process.

GDSP will continue to administer and evaluate the Prenatal Screening Program. Non-Invasive Prenatal Testing (NIPT) has been added to the list of covered follow-up services for those with elevated risk for having a baby with Down syndrome. NIPT would be offered as a choice for women alternative to amniocentesis and chorionic villus sampling (CVS). GDSP is exploring ways of offering NIPT as a first-tier prenatal screening test.

SCD and GDSP will continue to work together to address issues as they arise and update literature as needed. Despite the decreased staff, CCS will attempt to expedite authorizations appropriate for diagnosis and treatment of babies with positive results from newborn screening NBS.

Performance Measure 02

The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.

a. Last Year's Accomplishments
NPM 02 is one of five measures taken from the National Survey of CSHCN. Based on the 2009-2010 survey, 61.8 percent of CSHCN age 0 to 18 have families partnering in decision making at all levels and are satisfied with the services they receive.

1) County CCS programs collaborated with families to plan conferences on family participation in the CCS program.

2) The CRISS-FCC Work Group met several times to share ideas and resources; plan and coordinate conferences, trainings and activities; and monitor and promote transition activities, parent liaison services, and medical home projects.

3) FVCA Council Member Agencies held monthly meetings to address parent and community

involvement and monthly Brown Bag Lunch webinars statewide on issues affecting CSHCN.

4) FVCA Council Member Agencies provided workshops, presentations, and trainings to professionals and family members on C/YSHCN topics such as health care choices, family-centered care, partnering with parents/professionals, health delivery models, and leadership..

5) Some FVCA Council Member Agencies continued to renew their Parent Health Liaison contracts with their local Title V program (CCS).

6) FVCA developed a new pilot (funded by Lucile Packard Foundation) called "Project Leadership" to increase the number of family members of CSHCN, including those in CCS, who are prepared to partner and engage in all levels of public advocacy on behalf of CSHCN. The trainings to families in the San Diego/Imperial Counties region began September 2013.

7) LAPSNC worked with L.A. CCS and L.A. Family Resource Centers on improving the system of care for CSHCN in L.A. County. The meeting agendas were based on the MCHB core measures for children with special needs, focusing on self-education and advocacy.

8) The Los Angeles County CCS Workgroup, supported by LAPSNC, is a group of community stakeholders (providers, payers, community based organizations and parents) focused on improving the system of care for CSHCN in Los Angeles. The group followed an agenda based on the MCHB core measures for children with special needs, focusing on self-education and advocacy.

9) Los Angeles County CCS FCC Committee has been active for close to a decade. Members consist of parents of CSHCN and LAC medical, nurse and consultant staff. The FCCC collaborated with key agencies in the community (such as Family Voices; Family Resource Center; Patient Family Center Care Partners; CHLA UC Excellence in Developmental Disabilities) and was involved in many FCC activities, including review of communication with CCS families, education to CCS staff on FCC, "user friendliness" of transition forms, and problems encountered by clients/families when transitioning out of the CCS program.

10) Sonoma County CCS met regularly with Partnership Health Plan (PHP) and other PHP counties to discuss questions and issues. For FY 12/13, Sonoma mailed a Family Satisfaction Survey to enrolled CCS clients at the time of their annual program renewal. 97% of families reported being satisfied with the quality of services they received through the CCS Program.

b. Current Activities

1) Eleven counties are currently developing and implementing parent surveys for families

participating in the MTP.

2) In February 2014, FVCA held its 12th statewide Annual Health Summit in Sacramento,. The Summit focused on identifying and addressing challenges for CSHYCN.

3) FVCA continues their LPFCH funded pilot "Project Leadership".

4) FVCA continues to support and promote the use of CCS Parent Health Liaisons.

5) The Los Angeles County CCS Workgroup continues activities as described in Last Year's Accomplishments.

6) Los Angeles CCS FCC Committee continues to collaborate with key agencies.

c. Plan for the Coming Year

1) CSHCN stakeholder groups are included in the 2014 implementation of priorities selected for the 2015 Needs Assessment process.

2) Families included in stakeholder groups will continue to participate in activities to improve the delivery of care for CSHCN through the 1115 Waiver.

3) Family members will participate on advisory committees and in-service training of CCS staff and providers.

4) FVCA will continue to collaborate with SCD on family satisfaction issues and projects and respond to requests for input on materials and committees.

5) SCD medical director or designee will continue to attend bimonthly FVCA conferences and webinars.

CRISS convenes quarterly meetings of county CCS medical consultants, CRISS staff, and the CCS Chief Medical Officer in order to ensure consistent application of state CCS policy.

1) The FCC Committee in Los Angeles County CCS will continue activities, including education of new and existing staff on FCC; work with MTP Administration to review existing client satisfaction surveys; review of existing communication with CCS clients by nurse case manager staff; revision of existing LA Handbook for Clients/Families; and development of further strategies to enhance the relationship between local FRCs and MTPs.

2) LAPSNC will continue to collaborate with CSHCN organizations and parent groups to plan conferences and meetings.

Performance Measure 03

The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.

a. Last Year's Accomplishments

NPM 03 is from the National CSHCN Survey. Based on the 2009-2010 National Survey of CSHCN, 38.3 percent of the CSHCN in California receive coordinated, ongoing, comprehensive care within a medical home. The population in this survey is all CSHCN and is not restricted to CCS children. The survey estimate of 1 million CSHCN in California would indicate that around 25% of CSHCN have been CCS clients at any time in the past year. While many CSHCN are not eligible for CCS services, all CSHCN in CA benefit from the standards and infrastructure developed by the CCS program.

The state completed the expansion of MCMC services to all of California's 58 counties. With MCMC available statewide, many Medi-Cal members, including CSHCN in the CCS Program, will have a primary care physician and medical to coordinate all of their special health care to better manage their health condition. The CCS Program worked through 2013 to update and strengthen CCS case management procedures to accurately identify and appropriately document the client's primary care medical home provider in the CMS Net data system.

CRISS, through a grant from the San Francisco Foundation, extended their medical home activities from one CRISS county (Alameda) into three CRISS counties: Contra Costa, San Francisco, and San Mateo. CRISS works to implement regional and local strategies to promote medical homes for CSHCN, including distribution of updated hard copy medical home materials customized for each county in the CRISS region. Electronic medical home materials, including Child Health Notebooks, are available on the CRISS website.

The MCMC model of the CCS 1115 Waiver Program pilot began April 2013. Medical Home is incorporated into the comprehensive health care delivery system and is one of the areas of performance evaluation for the project.

b. Current Activities

1) State CCS is developing a medical home policy which supports the CCS program performance measure for medical homes.

2) CRISS continues to expand and improve the Alameda County Medical Home Project. The project targets clinics in Alameda with high numbers of CCS children. CRISS continues to recruit new sites, focusing on CHDP sites with high volumes of CCS children. The medical home project is currently active in 60 high volume sites in Alameda.38 of these sites include developmental screening and behavioral health assessments.

3) FVCA continues to promote collaboration of state and county CCS to identify and

implement program changes to make CCS more efficient, effective, and family-centered.

4) FVCA continues to provide information and trainings to families and professionals as described in Last Year's Accomplishments.

5) Sonoma CCS continues to strengthen the coordination of primary and specialty care through medical homes.

6) Sonoma CCS' medical home activities involve communicating with Partnership Health Plan (PHP) and attending quarterly CCS/PHP meetings.

c. Plan for the Coming Year

Plans for the coming year include:

1) CCS will continue to work with the counties to ensure CCS clients are connected to an appropriate medical home provide and will monitor the number of CCS clients who have a medical home identified in the database.

2) State CCS will work with counties and stakeholders, such as CRISS and FVCA, to develop a program policy specific to medical homes for CCS clients

3)

4) CRISS will continue to share Alameda County Medical Home Project activities and resources with three other counties, San Mateo, Contra Costa, and San Francisco.

5) CRISS will continue to provide technical assistance to sustain medical home approaches for CSHCN.

6) FVCA will continue to provide linkages to healthcare information to families and providers statewide through the FVCA listserv, council meetings and website.

7) Family Satisfaction survey planned for 2014 will assess whether clients receive coordinated care within a medical home.

8) The Medical Managed Care model of the CCS 1115 Waiver Program pilot continues to provide Medical Home into the comprehensive health care delivery system and the performance data continues to be analyzed.

9) SCD to clarify whether the CCS client's medical home is within the MCP or with a CCS-authorized primary care provider.

Performance Measure 04

The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

a. Last Year's Accomplishments

Efforts in 2013 to increase the percentage of families with insurance coverage included establishment of Covered California, a Health Benefit Exchange.

Beginning January 1, 2013 and through November 1, 2013, more than 750,000 Healthy Families Program (HFP) children were successfully transitioned to Medi-Cal. Infants previously enrolled into the HFP as a result of being born to a mother on the AIM Program with an income above 250 percent and up to 300 percent of the FPL were transitioned to DHCS and integrated into the new DHCS ALIP. Infants in the ALIP with CCS eligible medical conditions continued to receive case management and care coordination from the CCS Program.

By November 2013, California completed the expansion of Medi-Cal managed care services to more than 274,000 Medi-Cal members in 28 rural counties, bringing Medi-Cal managed care to all of California's 58 counties.

The state's Medi-Cal Program prepared to enroll between one million and two million newly eligible individuals as a result of the ACA.

b. Current Activities

1) Systems of Care Division (SCD) continues to collaborate with various stakeholders in helping to ensure that families of CSHCN continue to receive necessary services.

2) Infants in the ALIP with CCS eligible medical conditions will continue to receive case management and care coordination from the CCS Program.

   The CHDP Gateway pre-enrollment process serves as a means of assisting Medi-Cal eligible children and youth to access periodic preventive care.4. From January 1, 2013 through December 31, 2013, 461,774 children were pre-enrolled into Medi-Cal through the CHDP Gateway.

3) As of March 2014, over one million individuals are newly insured through Covered California.

c. Plan for the Coming Year

1) SCD will continue collaborative efforts with various stakeholders to identify and provide necessary services for CSHCN.
2) Infants in the ALIP with CCS-eligible medical conditions will continue to receive case management and care coordination from the CCS Program.
3) The CHDP Gateway pre-enrollment process will continue to serve as a means of assisting Medi-Cal eligible children and youth to access periodic preventive health assessments and the SCD will continue to support this process.
4) SCD will review the impact that Health Care Reform may have on families of CSHCN that are currently being served by CCS, AIM, and Medi-Cal.

5) As resources become available, SCD will continue to review initiatives that have the goal of promoting insurance coverage for children.

Performance Measure 05

Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.

a. Last Year's Accomplishments

NPM 05 is a National CSHCN Survey measure and is the percent of CSHCN age 0 to 18 years who can easily access community based services. For California in 2009-2010, the result was 64.8 percent.

The most recent National Survey of CSHCN, conducted by the Special Population Surveys Branch of the CDC National Center for Health Statistics (NCHS), identified approximately 750 parents of CSHCN in each state.

FVCA Council Member Agencies continued to work with their local CCS agency to provide trainings to CCS employees, and connect families to Family Resource Centers (FRC) for community resources, support and information.

The first 1115 Waiver Model, Medi-Cal Managed Care, began April 1, 2013 in San Mateo County. The contract requires coordination to improve access to community-based services as part of a whole child , family-centered health care approach.

Inter-county transfer policy was developed with stakeholder input to increase consistency in the application of policies and procedures across CCS counties.

Statewide CCS medical consultant group was established and meets frequently. Biannually a Southern CA medical consultant comes to the CRISS meeting, and a CRISS consultant attends the Southern California meeting.

b. Current Activities

1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) meets quarterly to improve consistency in interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the 27-county CRISS region.

2) The 1115 Demonstration Waiver Project pilot contract with Health Plan of San Mateo encompasses coordination of care with community support services to provide family-centered care coordination across the entire continuum of care.

c. Plan for the Coming Year

1) CRISS Medical Eligibility Work Group (CCS medical consultants, hospital and pediatric Representatives) will continue to meet quarterly to improve consistency in inter-county interpretation of CCS law, regulation and policy regarding medical eligibility and benefits in the now 27-county CRISS region.

2) CHDP, HCPCFC, and CCS programs will continue to report on a performance measure evaluating effective care coordination.

3) LAPSNC will continue to focus on increasing parent involvement by inviting representatives from FRC to meetings, joining committees and by supporting the CCS workgroup.

4) FVCA will continue to collaborate with DHCS on an ongoing basis and FVCA's council member agencies will work with their local CCS agencies to provide trainings to CCS employees, and connect families to FRCs for community resources, parent-to-parent support and information.

5) The FCCC will continue to review county FCC activities, share resources, and plan conferences, trainings, and activities.

6) SCD will continue to monitor the first 1115 Waiver CCS Demonstration Project, Medi-Cal Managed Care Pilot Model. Monitoring will include but is not limited to analyzing encounter data to ensure family-centered care, appropriate healthcare, and community-based services have been and continue to be accessible. and will monitor the number of CCS clients who have a medical home identified in the database.

Performance Measure 06

The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.

a. Last Year's Accomplishments

CCS strengthened health care transition planning case management procedures for the CCS client beginning at 14 years of age.

Several county CCS programs: Alameda, Los Angeles, San Diego, and Sonoma had effective transition planning. Alameda CCS distributed Child Health Records through the FRN; Santa Clara CCS distributes a booklet called “All About Me”; and San Mateo and Sacramento CCS distribute handbooks on transition called “Moving On”. The FCC Committee in Los Angeles County (LAC) CCS evaluated, “user- friendliness” of transition forms, and problems encountered by clients/families when transitioning out of the CCS program.

SCD implemented an Age-Out Program designed to assist young adults who are currently receiving EPSDT PDN and/or PDHC services and who will age out of the EPSDT service category when they reach their 21st birthday. SCD will identify these young adults three years before they reach the age of 21 to develop a care and resource plan based on the beneficiaries

level of care, medical needs, and home nursing needs. SCD will conduct home visits with these beneficiaries and case manage them until 21 years of age.

CRISS promoted family-centered care in CRISS counties, including transition planning efforts led by a transition specialist. CRISS provided state and county CCS transition resources and materials on their website – including: the Alameda County Medical Home Project Transition Guide which provides information on transition from pediatric to adult services; and resources from the Adolescent Health Transition Project, Department of Rehabilitation, Disabled Students Programs and Services, Regional Occupational Centers and Programs, and WorkAbility Programs.

b. Current Activities

CRISS and CCS county programs continue to promote transition planning efforts as described in Last Year's Accomplishments. The Medi-Cal Managed Care model of the CCS 1115 Waiver Program pilot began April 2013. Transition services is incorporated into the comprehensive health care delivery system.

c. Plan for the Coming Year

1) State CCS will continue working with counties to develop new transition planning performance measures for CCS children. The new performance measures align with HRSA's guidelines for family- centered transition planning services.

2) State CCS will work to change current "recommendation" for transition planning to required policy procedures.

3) The FCC Committee in Los Angeles County CCS will continue activities, including creation of other activities in an extensive Scope of Work which includes education of new and existing staff on FCC; review of existing communication with CCS clients by nurse case manager staff; and examination of ways to enhance the relationship between local FRCs and MTPs.

4) State CCS will continue collaboration with counties, CRISS, and FVCA on transition issues for CSHCN.

5) State CCS will work with county programs, such as Alameda, Los Angeles, San Diego, and Sonoma, who have high percentage of staff compliance in transition planning activities to share their transition successes and ideas with other CCS counties via committees, conferences and/or webinars.

6) The Medical Managed Care model of the CCS 1115 Waiver Program pilot will continue to ensure enrollees have a transition plan completed on an annual basis beginning at 14 years of age.

Performance Measure 07

Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

a. Last Year's Accomplishments

In 2012, the immunization rate for children age 19-35 months was 73.5 %. However this rate should not be compared to those reported for prior years since there has been a change in the way Hib vaccination coverage is defined in that it takes into consideration the brand type of the vaccine.

MCAH and SCD advocated for families to enroll in Medi-Cal or HF. LHJs and MCAH programs, including CPSP, AFLP and BIH, continued to assess the immunization status of adolescent and women clients and their children on a periodic schedule, and promoted the importance of maintaining up-to-date immunizations by assisting program clients to access ongoing preventive care.

In 2011 (3,011 reported cases) and 2012 (1,022 reported cases), there were no recorded deaths attributed to pertussis.

MCAH continues to work with the IZB in promoting adolescent immunizations. Many MCAH LHJs conducted outreach at health fairs and other venues to provide education and resources for childhood/adolescent immunizations and health insurance. Programs such as CHVP, AFLP and BIH discuss and encourage clients to keep immunizations up-to-date. .

California's new personal beliefs exemption (PBE) law, (AB 2109), permits parents to request PBE from required immunizations for their children in child care or grade school. Under this law, the parents or guardians must document having obtained education about vaccine-preventable diseases and vaccines from an authorized health care provider. Many local MCAH programs focused activities on immunizations and participated on Immunization Collaboratives and coalitions to increase access to immunizations through health fairs, seasonal flu clinics and public health immunization clinics. For example, El Dorado County developed a vaccine safety and local resources campaign to target school districts with high Personal Belief Exemption rates.

The Perinatal Hepatitis B program enhanced the capacity of providers to integrate Hepatitis B Vaccine (HBV) testing, counseling and informed consent into their prenatal care services and in labor and delivery.

b. Current Activities

SCD and IZ Branches, Medi-Cal, and MCMC meet thrice annually to discuss results of the ACIP-VFC National Meetings. SCD and IZ branches work together on adding new vaccines and modifying existing vaccine benefits in concordance with ACIP recommendations.

MCAH partners with IZB to provide immunization updates to Perinatal Services Coordinators (PSCs), review and develop educational materials on immunizations during pregnancy and stress the importance of influenza and Tdap vaccinations.

MCAH and SCD advocate for and assist families to enroll in low/no cost public and private health insurance entities. In 2013, there were 2, 372 reported pertussis cases (increased from 2012) and one infant death. There is increased influenza activity for 2013-2014, with severe respiratory illness reported among young and middle-aged adults, many of whom were infected with H1N1 virus. California had more than330 confirmed influenza-related deaths as of March 2014.

California usually has less than 40 measles cases reported annually after the U.S eradicated measles in 2000. As of March 2014, confirmed measles cases jumped to 49.

LHJs are conducting flu clinics that provide free vaccinations in their communities, especially to vulnerable MCAH populations.

MCAH and the IZ Branch partner with Text4Baby to remind mothers to immunize their babies and educate parents that all incoming 7th grade students will need a whooping cough booster immunization before enrollment.

c. Plan for the Coming Year

SCD and IZ Branch, Medi-Cal, and MCMC continue to meet three times per year to discuss results of the ACIP-VFC National Meetings. SCD and IZ branches work together on adding new vaccines and modifying existing vaccine benefits in concordance with the ACIP recommendations.

MCAH partners with the IZB to provide immunization updates to MCAH Perinatal Services Coordinators, review immunization brochures on immunization during pregnancy, and emphasize the importance of influenza and Tdap vaccination for pregnant women and others in contact with young infants. MCAH continues to work closely with IZB to provide information on pertussis and influenza to MCAH providers.

ACA provider payments will include a significant increase to physicians performing health assessments and administering vaccinations to children.

Performance Measure 08

The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

a. Last Year's Accomplishments

The overall birth rate to teens aged 15-17 dropped from 14.8 in 2011 to 13.1 per 1,000 in 2012 representing 11.5% decline; the Hispanic teen birth rate decreased 11.5%, from 23.4 to 20.7 (per 1,000 female teens aged 15-17 years) and the African American teen birth rate declined 19.2%, from 17.2 to 13.9 (per 1,000 female teens aged 15-17 years). The teen birth rate for Whites decreased 6.8%, from 4.4 to 4.1 (per 1,000 female teens aged 15-17 years) and the Asian/Pacific Islander teen birth rates decreased 14.8%, from 2.7 to 2.3 (per 1,000 female teens aged 15-17 years). Rates for White and Asian/Pacific Islander teens continue to be lower than rates for Hispanic and African American teens.

OFP, Family Planning, Access Care & Treatment program (Family PACT), the California Personal Responsibility Education Program (CA PREP), and the Information &Education Program (I & E) continued their teen pregnancy prevention efforts. However, budget reductions resulted in less program evaluation, education, and outreach for teen pregnancy prevention programs.

Twenty-four I & E grantees continue to operate with funds awarded in 2011.

In 2012, CDPH/OFP was awarded $6.5 million annually through the CA PREP funds administered by the Family and Youth Services Bureau. Currently, CDPH/MCAH monitors these funds that replicate effective evidence-based program models that have been proven to change behavior .in19 California counties with the highest teen birth rates.

MCAH continued to fund and monitor AFLP. The number of AFLP sites has declined from 41 in 2009 to 32 in 2013.

MCAH implements a Support for Pregnant and Parenting Teens at High Schools and Community Service Centers award funded through the ACA Pregnancy Assistance Fund (PAF) and administered by the federal Office of Adolescent Health that provides $2 million annually for federal project periods 2010--2013. MCAH is developing a standardized case management model with integrated life planning for AFLP.

This grant is called AFLP PYD (Positive Youth Development), and it is being implemented in 11 AFLP sites. Activities included capacity building through a series of five trainings: Core Competencies for Providers of Adolescent Sexual and Reproductive Health; Positive Youth Development (PYD); Motivational Interviewing and Case Management; Life Planning; and "Pulling It All Together." The "Pulling It All Together" training provided skill building for local partners to practice using the newly developed, PYD-informed My Life Plan modules and corresponding Goal Setting tools in preparation for pilot implementation.

In April 2013, MCAH applied for the Office of Adolescent Health (OAH) grant for the Support for Expectant and Parenting Teens, Women, Fathers and Their Families to conduct

outcome evaluation on its AFLP PYD intervention. In June 2013 was awarded $1.5 million annually for 4 years.

Cal-SAFE continued serving pregnant and parenting students. Some school districts have closed or decreased their Cal-SAFE programs, since flexible spending was implemented.

b. Current Activities

From last year's competitive grant process, MCAH monitors grantees in 19 California counties with the highest teen birth rates. MCAH continues to provide the necessary infrastructure to support effective program implementation including training, technical assistance, and systems for data collection, monitoring and evaluation.

I&E continues its teen pregnancy prevention efforts.

MCAH continues to support LHJs and CBOs that implement the AFLP program, particularly as they address the challenges of ongoing funding reductions. MCAH is piloting the AFLP PYD intervention in its 11 funded sites through a formative evaluation by an independent evaluator in order to develop a standardized case management intervention. Activities have focused on revising the intervention tools based on program implementation with active participation by all sites through site calls, surveys, key informant interviews, and focus groups with clients.

In addition, with new grant funding, MCAH is preparing for the AFLP PYD outcome evaluation. MCAH is currently working with Mathematica, as the AFLP PYD intervention is being considered for national evaluation.

c. Plan for the Coming Year

There are 38 counties with teen pregnancy prevention programs.
With newly integrated primary teen pregnancy prevention programs, MCAH looks forward to developing an enhanced focus on primary and secondary teen pregnancy prevention, youth sexual health and adolescent health promotion. These efforts will include an emphasis on positive youth development and healthy relationships with the goal of promoting adolescent sexual health as well as overall health and well-being. In addition, opportunities to leverage coordination of primary and secondary teen pregnancy prevention efforts will be identified in terms of local and expert input; professional development and training; replication and effective adaptation of evidence-based practice; process and program evaluation; and continuous quality improvement. This youth focus is supported by the local MCAH needs assessments which have identified adolescent health and adolescent reproductive health as local priorities.

MCAH will continue primary teen pregnancy prevention efforts through I & E and CA PREP but with a broader goal of youth sexual health. CA PREP will continue program implementation and MCAH will work with UCSF and the CA Prevention Training Center to support and monitor local implementation and program quality in an effort to meet or exceed federal performance measures.

MCAH will continue to implement AFLP and apply the best practices learned from the AFLP PYD efforts into the overall statewide AFLP program. MCAH plans to work with the OAH, as it develops its outcome evaluation for AFLP PYD. .

Performance Measure 09

Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

a. Last Year's Accomplishments

Children's access to preventive dental services is assessed in relation to the percent of third grade children who have received protective sealants on at least one permanent molar tooth. The percentage of children with sealant in California is estimated to be 27.6 percent. A new survey has not been implemented since 2005 to update this rate. So, for 2012, the percentage of Medi-Cal beneficiaries ages 6-9 who are eligible for EPSDT for 90 continuous days for FFY 2012. The data is from the CA Department of Health Care Services, Systems of Care Division. Form CMS-416, Annual EPSDT Participation Report, FFY 2011-2012.

To meet the demand for TA, MCAH contracts with UCSF School of Dentistry for a dental hygienist to serve as the MCAH Oral Health Policy Consultant. MCAH, SCD, Medi-Cal and OHU are members of the California Oral Health Access Council (OHAC) and the Oral Health Work Group (OHW). OHAC is a diverse panel of stakeholders that are working to improve the oral health status of the state's traditionally underserved populations. OHW assists in the coordination of state oral health activities and serves as a clearinghouse for member organizations. In addition, MCAH, OHU and Medi-Cal are liaisons to the CHDP State Dental Subcommittee whose goal is to increase access to dental care for the CHDP eligible population.

About one-third of LHJs actively provides education, screenings, referrals and limited dental services for children and pregnant women. LHJs also rely on collaboration with local oral health coalitions to bring outreach programs and preventive services to MCAH target populations. Many LHJs select WIC sites, pre-schools, and public school locations to deliver these services. MCAH case management programs, such as CPSP, BIH and AFLP, enroll women and their families into Medi-Cal and provide them with necessary dental referrals.

California law requires that children receive a dental check-up within the last 12 months and up to May 31 of their first year in public school (kindergarten or first grade). Schools are encouraged to collect and submit data but are not mandated to do so because of state budget cuts. Last year, the California Dental Association collected assessment data from 42% of the school districts; 116,974 out of 191,192 eligible children submitted an assessment during the school year. Approximately 20.5% were found to have untreated decay, an increase over last year's results of 18.7%.

From January through November 2013, over 750,000 children, who were enrolled in the Healthy Families Program in 2012, transitioned into Medi-Cal's Targeted Low Income Children's Program, covering children with income up to and including 250 percent of federal poverty level. Another 287,000 newly enrolled children were added. Families needing to locate

a new dentist can use the Beneficiary Customer Service line, which provides warm transfers (ensuring beneficiaries are connected to a provider and attempting to schedule an appointment before disconnecting from the call). The Denti-Cal website also includes provider network information allowing individuals to search for providers by state, name of provider, location of residence, specialty, accepting new patients, and other factors through the Insure Kids Now widget. Recruitment for providers who practice in communities with low Denti-Cal participation continues.

OHU is working with the University of the Pacific and other partners to implement an Oral Health Workforce Grant. Activities include developing a dental prevention and treatment pilot project in schools with FQHCs as a direct service model; identifying strategies to increase the current dental health workforce and addressing policy barriers; the development of an initial framework for a "value-based" payment mechanism for oral health services, and developing tool kits to implement school-based dental prevention programs. OHU's Community Water Fluoridation Program provides technical assistance to public water systems, local health jurisdictions, health providers, and other interested organizations and/or individuals regarding fluoridation. In 2012, the percentage of Californians receiving fluoridated water increased from 62.1-63.7%.

b. Current Activities

MCAH promotes the California perinatal clinical oral health guidelines to assist health care professionals deliver oral health services to pregnant women and their children. MCAH also dispatches updated information, web links, grant resources and educational materials to local oral health advocates and coordinators. One area of interest is the new pediatric dental benefits offered by CA Health Benefit Exchange. MCAH has closely observed the creation of the Covered CA website and the process parents encounter when signing up for 2014 stand-alone dental plans for their children.

MCAH assists LHJs in developing oral health activities to increase community access and outreach. For example, two oral health 5-year work plans are posted for LHJs to use in preparing objectives and activities for their SOWs. The goal of one work plan is to increase access and link children to a dental home where possible to ensure they get preventive care on an annual basis. The goal of the second work plan is to increase access for women to receive oral health care by a dentist during their pregnancy.

An effort to integrate oral health into CHVP has begun. The MCAH oral health consultant participates in meetings with local program staff to share information on finding Medi-Cal dental providers for both pregnant women and their children and tips on oral health care. Beginning January 2014, the consultant joined the staff of CHVP to incorporate more oral health activities into local programs.

c. Plan for the Coming Year

MCAH will continue to promote and disseminate the California perinatal clinical oral health guidelines for health care providers. Since the guidelines were released in 2010, MCAH hopes to detect an increase in the number of pregnant women receiving prenatal oral health counseling. Two multi-part questions from the 2009 MIHA survey were added back into the

2012 MIHA survey to discern any change among respondents. Data analysis is currently underway.

MCAH is collaborating with DHCS to develop a State Action Plan to address two national Medicaid goals for oral health improvement in children. The first goal is to increase by 10 percentage points the proportion of children enrolled in Medicaid that receive a preventive dental service, over a 5-year period. The second goal is to increase by 10 percentage points the proportion of children ages six to nine enrolled in Medicaid that receive a dental sealant on a permanent molar tooth. Proposed activities include: work with local CHDP programs to identify and assist children in need of dental services; increase the number of school-based programs providing sealants; aid FQHCs in reporting dental services; encourage Head Start and WIC programs to bill for fluoride varnish applications; and allow registered dental hygienists (RDHs) to become Denti-Cal billing providers.

In July 2009, state officials cut Medi-Cal services including eliminating coverage for adult dental care. However, in accordance with the decision by the US Court of Appeals for the Ninth Circuit, all adult dental services are now reimbursable Medi-Cal services when provided by FQHCs and Rural Health Centers beginning on September 26, 2013.

In addition, health budget bill AB 82 declared that beginning May 1, 2014, the following dental benefits will be restored to three million Medi-Cal beneficiaries age 21 and older: initial examinations, radiographs/photographic images, prophylaxis, and fluoride treatments; amalgam and composite restorations; prefabricated stainless steel, resin, and resin window crowns; anterior root canal therapy; complete dentures, including immediate dentures; and complete denture adjustments, repairs, and relines.

The Children's Partnership, an advocacy group, is supporting AB 1174 to approve Medi-Cal reimbursements for tele-dentistry. The bill would emulate the Virtual Dental Home pilot project at the University of the Pacific's School of Dentistry. Under the program, RDHs in alternative practice, RDHs working in public health programs, and registered dental assistants can keep people healthy in community settings by providing education, preventive care, interim therapeutic restorations triage, and case management. Radiographs and pictures are transmitted to collaborating dentists who diagnose and prescribe all treatment.

The Board of the CA Health Benefit Exchange has decided to offer embedded pediatric dental benefit plans side by side with a stand-alone benefit plans for 2015 in the individual market.

Performance Measure 10

The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

a. Last Year's Accomplishments

CIPPP maintained a calendar of online training opportunities and webinars to partially fill the gap created by declining resources and travel restrictions for in-person training opportunities.

CIPPP developed age-appropriate recommendations to parents of infants, toddlers, children and adolescents for keeping their children safe at home, at play, and when traveling. These "Be Safe, Not Sorry" sheets are available in English, Spanish, and Vietnamese languages. SafetyLit services were enhanced through a complete redesign of the website interface, an improved search system, and the addition of gray literature (conference proceedings, doctoral theses, and technical reports), and of books and book chapters to the existing articles drawn from >12,000 scholarly journals published in 142 of the world's nations. These prevention articles (from places with different populations and cultures, different fiscal situations, and different levels of personnel and personal training and skills) can be readily adapted to inform activities in California's rural and inner city areas.

b. Current Activities
The CIPPP contract was cancelled in 2013/14 due to reductions in Title V funding.

c. Plan for the Coming Year
Due to the reduction of Title V funds there are no planned activities of MCAH.

Performance Measure 11
The percent of mothers who breastfeed their infants at 6 months of age.

a. Last Year's Accomplishments
MCAH developed a webpage and authored a letter to hospitals from WIC and MCAH providing them with resources and notification regarding CA Health & Safety Code SS123366, the Hospital Infant Feeding Act.

MCAH authored a letter from WIC and MCAH to CDC to support the continuation of MPINC, a national survey of maternity care practices and policies conducted every two years by the CDC.

The infant feeding guidelines for AFLP, CDAPP: Sweet Success and CPSP were updated with more current and science-based information.

MCAH developed a Systems and Environmental toolkit and webinar that support breastfeeding. The resources chosen are feasible projects for MCAH Program involvement. A success story shared in the toolkit is that during this year, the City of Pasadena's MCAH program is working to implement a citywide workplace breastfeeding policy as well as a department-wide Mother-Baby Friendly workplace. They hope to make Pasadena a Mother-Baby Friendly community by 2015.

MCAH collaborated with the CA Breastfeeding Coalition, the CA WIC Association and State programs to host the 3rd Annual CA Breastfeeding Summit on 01/31 - 02/01/13.

MCAH and SCD provided the DHCS, data and technical assistance in support of a quality improvement project to increase breastfeeding among Medi-Cal recipients as part of the DHCS Quality Strategy.

MCAH programs promoted exclusive breastfeeding until complementary foods are introduced and continued breastfeeding for at least the first year of life.

MCAH shared information with its programs during World Breastfeeding Week and encouraged county and community-based organizations to participate. MCAH coordinated with the CA Obesity Grant, WIC, WIC Association, and Breastfeeding Coalition to celebrate World Breastfeeding Week with a breastfeeding walk.

MCAH supported CDPH and DHCS in adhering to CA Health & Safety Code SS 123360 in creating a public health campaign to provide breastfeeding information and referrals, making available an 8-hour training course that promotes exclusive breastfeeding, and assisting hospitals in developing policies to support breastfeeding by keeping the Model Hospital Policy Recommendations Toolkit and hospital quality improvement resources updated. Per CA Health & Safety Code SS123365, WIC and MCAH finalized a hospital administrators web-based breastfeeding policy curriculum.

PAC-LAC, a RPPC region and MCAH published a report outlining elements and lessons learned from BBC. MCAH offers technical assistance to implement BBC and worked with FHOP to develop a BBC/breastfeeding webinar and breastfeeding fact sheet.

MCAH hospital initiation breastfeeding data was posted online and used by the CA WIC Association and UCD to produce a Hospital Breastfeeding Rates Report & County Fact Sheets. MCAH collaborated with CDC to show that evidence-based policies and practices measured by MPINC are associated with increased exclusive breastfeeding rates in CA hospitals; county and regional MPINC benchmark report were posted online and shared at the annual Hospital Breastfeeding Summit.

MCAH participated in RPPC's emergency preparedness efforts for birthing hospitals and posted related resources on the web.

For home visiting efforts, MCAH developed breastfeeding benchmark indicators and researched WIC's Peer Counselor Curriculum.
Several LHJ activities promote breastfeeding. For example, Kings County collaborated with the local breastfeeding coalition to develop a "breastfeeding friendly sites" directory. Marin County adopted a workplace breastfeeding policy. Solano County implemented the "More Excellent Way," an African American, peer counseling, church-placed infant feeding and parenting training and intervention program.

El Dorado County had an "Express Stop" to loan breast pumps to local employers to help them meet workplace requirements. Fresno County prepared a training "How to Provide Breastfeeding Education and Support in CPSP" in collaboration with the WIC program. Kern County received input from nurses in their LHJ to improve the breastfeeding curriculum at California State University, Bakersfield.

b. Current Activities

MCAH collaborated with WIC, CA Obesity Prevention Program, CA Breastfeeding Coalition, and the CA WIC Association to host the Annual CA Breastfeeding Summit 2014 where MCAH showcased the improved easy to navigate CDPH Breastfeeding web page. Breastfeeding posters were shared at Chronic Disease's Advancing Prevention in the 21st Century Commitment to Action 2014 Conference.

RPPC coordinators are addressing the Infant Feeding Act which requires hospitals to have an infant feeding policy, including promotion of the Annual Breastfeeding Summit, provided breastfeeding trainings, information and data to regional hospitals, CHDP promotes and supports breastfeeding through nutrition assessment, anticipatory guidance, training for medical providers and ensuring referrals are made to WIC and other health programs. CHDP assists WIC with breastfeeding specific trainings for CHDP providers and CHDP county staff.

Using CDC funds, MCAH collaborated with the CA Obesity Prevention Program (COPP) on a statewide pilot project focused on increasing breastfeeding duration rates in California's low-income communities of color. 15 community health centers received training, technical assistance, and resources to assist them 1) implement a "breastfeeding-friendly" environmental and policy changes, and 2) improve reimbursement policies. Successful pilot strategies will be highlighted and shared for clinics statewide to adopt specific model "breastfeeding-friendly" clinic policies/practices.

c.

d. Plan for the Coming Year

MCAH will strive to maintain its lead with the most Baby-Friendly certified hospitals (59) in the U.S. MCAH provides resources on the CDPH web page to implement CA Health & Safety Code SS123366, the Hospital Infant Feeding Act and SS123367 (2013) which requires all general acute care hospitals and special hospitals that have a perinatal unit shall, by 2025, adopt the "Ten Steps to Successful Breastfeeding," per the Baby-Friendly Hospital Initiative, or an alternate process adopted by a health care service plan that includes evidenced-based policies and practices and targeted outcomes, or the CA Model Hospital Policy Recommendations.

MCAH will continue to collaborate with the Office of Emergency Preparedness to develop an infant feeding policy with recommended tools that focus on keeping the mother-infant dyad together and supporting breastfeeding as the preferred and safest infant feeding method.

MCAH will continue to support conferences/meetings such as the Hospital Breastfeeding Summit, and Childhood Obesity Conferences.

MCAH will continue to have a representative on the U.S. Breastfeeding Committee and the Association of State Public Health Nutritionists (ASPHN) MCH Nutrition Council which address breastfeeding strategies. She participates in the following USBC workgroups: Emergency Preparedness, Media/Public Relations and the Reduce Infant Formula Marketing. MCAH collaborates on promoting breastfeeding within CDPH via a Center for Family Health Nutrition Coordination Workgroup and the Obesity Prevention Group.

Example 5Year Action Plan on breastfeeding provided to Local Health Jurisdictions include:

- Develop a lactation accommodation plan that addresses current national and state laws
- Adopt practices that support the exclusive initiation of breastfeeding within labor and delivery facilities as per state law
- Adopt practices that support breastfeeding within health centers
- Expand breastfeeding support within MCAH programs
- Include breastfeeding support within emergency preparedness plans

The SCD Registered Dietitian/Lactation Consultant will continue to provide specialized assistance in support of the quality improvement project to increase breastfeeding rates among Medi-Cal recipients as part of the DHCS Quality Strategy.

Performance Measure 12

Percentage of newborns who have been screened for hearing before hospital discharge.

a. Last Year's Accomplishments

1) SCD provided TA and consultation support to HCCs to ensure that all general acute care hospitals with licensed perinatal services provide hearing screening tests to all newborns in a manner consistent with NHSP standards and requirements.
2) SCD continued to facilitate the NHSP Quality Improvement learning collaborative.
3) SCD was awarded continued funding from MCHB for the tele-audiology project to improve the quality of and access to audiology services and minimize the shortage of pediatric audiology providers in Northern California.
4) SCD collaborated in the implementation of the parent support grant from MCHB.
5) SCD worked with the NHSP Data Management Service (DMS) vendor, Neometrics, to implement the DMS in all HCCs and to roll out the implementation in hospitals statewide.

b. Current Activities

1) All new general acute care hospitals with licensed perinatal services will be certified for participation in the NHSP.
2) SCD continues collaboration in the implementation of the parent support grant from MCHB.
3) The NHSP DMS vendor is implementing the DMS in additional hospitals.
4) SCD is an active participant in the NHSP QI learning collaborative.
5) SCD provides technical support to the HCCs.
6) SCD continues to collaborate with UC Davis Hospital to execute the activities in the tele-audiology grant.
7) SCD continues to work with Medi-Cal and its fiscal intermediary to address issues affecting access to outpatient hearing screening and audiology services.
8) SCD is initiating collaboration with UCLA for a comprehensive evaluation of the NHSP.

c. Plan for the Coming Year

1) SCD will finalize the certification of any new hospitals.

2) SCD will continue to collaborate in the implementation of the parent support grant from MCHB.
3) The DMS for NHSP will be rolled out to all remaining certified hospitals throughout the state.
4) SCD will continue participation and facilitation of the NHSP QI learning collaborative.
5) TA and consultation support will continue for all HCCs to ensure compliance with NHSP standards and requirements.
6) The Audiology Telehealth pilot project in the rural northern region of California will allow rural families to receive local diagnostic services without lengthy travel.
7) SCD will collaborate with UCLA in the evaluation of NHSP.

Performance Measure 13

Percent of children without health insurance.

a. Last Year's Accomplishments

The percent of uninsured children in California has decreased since 2000 when the percent of children without health insurance was 15.7%. Over a million children still lack coverage. Data for NPM 13 are based on the U.S. Current Population Survey. Medi-Cal continues to fill the gap in coverage created by the decline in private insurance. Children received coverage from three main sources of coverage: job-based insurance, privately purchased insurance and Medi-Cal.

California began the process of combining Medi-Cal and the Healthy Families Program (HF). Beginning January 1, 2013 and through November 1, 2013 children who in the past would have enrolled in HF became eligible for full-scope, no share-of-cost Medi-Cal under a new Medi-Cal Optional Targeted Low-Income Children's (OTLIC) Program. Infants previously enrolled into HF as a result of being born to a mother on the AIM Program with an income above 250 percent and up to 300 percent of the FPL were transitioned to the new DHCS AIM-Linked Infants Program (ALIP).

Local MCAH programs, including AFLP, BIH, and CPSP, provided outreach and facilitated referrals to Medi-Cal, CHI, and Covered California insurance and care for pregnant women, infants and families, focusing on high risk populations. Activities included case finding, care coordination, public awareness media campaigns, and other targeted community education and outreach efforts. High-risk groups included CSHCN, low income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes. Counties continue to provide assistance in Medi-Cal applications at County social service offices.

Medi-Cal Managed Care (MCMC) expanded into 28 rural counties that were formerly Fee-For-Service (FFS) only. By November 2013, California completed the expansion of MCMC services to all of California's 58 counties. This expansion provided beneficiaries throughout the state with care through an organized delivery system.

Many counties continued to provide coverage through Children's Health Initiatives (CHI) to locally fund insurance programs for children ineligible for Medi-Cal coverage. CHI is a collaboration of 29 local CHI's dedicated to ensuring that all California children have access to quality health coverage.

Local CHDP programs informed new providers about the Gateway and directed them to CHDP Gateway resources. The Systems of Care Division (SCD) continued to analyze CHDP Gateway data reports to monitor program operations and the needs of local programs and providers.

Through the CHDP Gateway, any child under 19 years with family income up to 200% of the FPL (and not already in the Medi-Cal Eligibility Data System (MEDS) system) is "presumed eligible" for Medi-Cal and given a temporary Medi-Cal Benefits identification card. This provides access to no-cost, full scope fee-for-service Medi-Cal benefits for up to 60 days. Most families with children pre-enrolled through the CHDP Gateway (91 percent) request a Medi-Cal/ application for ongoing coverage at the time of the pre-enrollment through the CHDP Gateway. Seventy-six percent of CDPH applications come from the Gateway. Twenty-three percent of children enrolled in CHDP from the Gateway go on to enroll in full-scope Medi-Cal.

Since December 2010, Californians have been able to use a self-service, online application for the Medi-Cal Program for Children and Pregnant Women. This enrollment option, called Health-e-App Public Access (HeAPA) offers a faster and more convenient access to public insurance for children. Its first full year of operation was 2011. Through the CHDP Gateway, any child under 19 years with family income up to 200% of the FPL (and not already in the Medi-Cal Eligibility Data System (MEDS) system) is "presumed eligible" for Medi-Cal and given a temporary Medi-Cal Benefits identification card. This provides access to no-cost, full scope fee-for-service Medi-Cal benefits for up to 60 days. Most families with children pre-enrolled through the CHDP Gateway (91 percent) request a Medi-Cal/ application for ongoing coverage at the time of the pre-enrollment through the CHDP Gateway. Seventy-six percent of CDPH applications come from the Gateway. Twenty-three percent of children enrolled in CHDP from the Gateway go on to enroll in full-scope Medi-Cal.

Local CHDP programs informed new providers about the Gateway and directed them to CHDP Gateway resources. The SCD analyzed CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

b. Current Activities

MCAH programs, including AFLP, BIH, and CPSP, encourage and facilitate enrollment in Covered California, Medi-Cal and CHI through outreach, education and referral programs.

California began enrollment in ACA-compliant health insurance plans in September 1, 2013.. DHCS partners with Covered California to provide a one-stop shop for application to Medi-Cal or Covered California health coverage.

California implemented the Targeted Low Income Children’s Program. California Children's Services provides coverage for certain medical conditions for families with incomes less than $40,000 or expenses more than 20% of their income.

Local CHDP programs inform new providers about the Gateway and direct them to CHDP Gateway resources. SCD will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.
Infants in the new DHCS AIM-Linked Infants Program (ALIP) with CCS eligible medical conditions continue to receive case management and care coordination from the CCS Program.

DHCS implemented the use of the MAGI as an expansion of Medi-Cal to include those who are up to 266% of the FPL. This is an increase from the 200% of the FPL for the MAGI eligible population.

c. Plan for the Coming Year

California will continue to conduct outreach and education to encourage and facilitate enrollment in Covered California, Medi-Cal and other health insurance. California will continue to implement the Health Benefit Exchange to enroll eligible residents into Covered California health plans and DHCS will monitor and facilitate the Medi-Cal enrollment process.

Local MCAH programs will continue to provide outreach and referrals to health insurance coverage for pregnant women, infants, and families and provide supportive activities to ensure continuous access to recommended health care services. These activities may include identification of high risk populations, targeted outreach, case finding and care coordination for women, children and adolescents who are not linked to a source of care. Other high risk groups targeted are CSHCN, low income pregnant women, and women of childbearing age who are at risk for adverse perinatal outcomes.

Local CHDP programs will continue to inform new providers about the Gateway and direct them to CHDP Gateway resources. SCD will continue to analyze CHDP Gateway data reports to monitor program operations and the needs of CHDP local programs and providers.

Local CHDP programs will continue work with the fee-for-services health assessment providers on the referrals, and coordination of care for the residual beneficiaries who remain in fee-for-service Medi-Cal. SCD will continue to maximize the effectiveness of the Gateway for enrolling eligible children in Medi-Cal.

Performance Measure 14

Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.

a. Last Year's Accomplishments

MCAH continued to focus on a life course perspective for addressing childhood obesity: preconception, pregnancy, interconception, infant feeding all have an effect on childhood obesity.
MCAH provided expert input for the 2013 Childhood Obesity Conference. MCAH continued existing and began new collaborations, such as with the Coordinated Chronic Disease Program.

An online toolkit to provide nutrition, physical activity and breastfeeding resources for LHJ-MCAH Programs to address the built environment was developed and includes a sample PowerPoint and webinar featuring Dr. Richard Jackson and local MCAH Directors.

The revised CDAPP Sweet Success Guidelines for Care include medical nutrition therapy, breastfeeding and exercise sections. The Spanish CA MyPlate for Gestational Diabetes handout was developed. The CDAPP Sweet Success Resource and Training Center provided webinars on diabetes and pregnancy, e.g., on nutrition, eating for the holidays and exercise.

Extensive activities were implemented to promote breastfeeding (see NPM 11). BIH updated their curriculum to include breastfeeding and maternal weight.

MCAH finalized English and Spanish healthy cookbooks for AFLP to encourage healthy eating and physical activity. The physical activity section of the AFLP Nutrition and Physical Activity Guidelines was revised.

As part of a life course approach to prevent obesity, a MCAH webpage shares strategies and community-based interventions that support healthy weight for reproductive-aged women. MCAH assisted in developing interconception guidelines/handouts for women with risks, e.g., gestational diabetes, in a prior pregnancy. MCAH collaborated with FHOP to create a healthy weight webinar and fact sheet.

CPSP's Steps to Take Guidelines include a section on breastfeeding and MyPlate for Moms. CPSP nutrition, physical activity and breastfeeding handouts are posted online. MyPlate for Moms is a primary message for CPSP and AFLP. Prenatal weight gain grids were created for pregnant women with twins. In collaboration with UCLA, a CPSP Perinatal Food Group Recall which identifies food group and calorie deficiencies/excesses was evaluated for accuracy and ease of implementing by CPSP Community Health Workers. Findings and recommendations were presented to Perinatal Services Coordinators.

MCAH researched nutrition, physical activity and breastfeeding benchmarks for home visiting and disseminated WIC child nutrition and baby behavior educational materials to local MCAH.

MCAH helped author national guidelines released in 2011 promoting optimum nutrition, breastfeeding and physical activity in childcare centers.

Many laws were passed to support CDPH efforts to reduce obesity, such as making obtaining federal funds easier for CDPH and establishing a "Safe Routes to School Program."

State and local CHDP nutritionists developed and implemented nutrition education curricula, provided consultations, trained staff, and monitored childhood obesity. Online training modules

for assessing and managing overweight children were updated and utilized by MCMC Health Plans and CHDP providers. CHDP nutritionists trained medical providers and clinic staff on the use of the WHO Growth Charts and the use of BMI as a screening tool for overweight and obesity CHDP nutritionists collaborated with numerous other public health entities including WIC and the Active and Healthy Families Program regarding obesity prevention and management.

The MCAH Nutrition and Physical Activity Coordinator was a Board member of the Association of State Public Health Nutritionists (ASPHN) and MCH Nutrition Council, which works to strengthen nutrition strategies, programs and environments at state and national levels. MCAH collaborates within CDPH via a Center for Family Health Nutrition Coordination Workgroup and the Obesity Prevention Group.. MCAH and SCD participated on the Obesity Prevention Group (OPG), which aims to integrate obesity prevention into CDPH programs.
Examples of local MCAH activities include nurses promoting healthy eating habits and increased physical activity to Alameda female clients of childbearing age. Monterey provides cooking demonstrations to migrant families. Riverside updated a Child and Adolescent Obesity Provider toolkit. San Francisco developed guidelines to improve physical activity and nutrition in child care centers and after school programs. Stanislaus promoted a built environment to support physical activity.

b. Current Activities
MCAH completed revisions to the weight management and nutrition assessment sections for the AFLP Nutrition and Physical Activity Guidelines.

MCAH is participating in a Physical Activity (PA) Collaborative Impact Planning Group. In these sessions CDPH physical activity staff are 1) sharing about our current/future CDPH PA projects, programs, and interventions, 2) identifying where there are opportunities to integrate our PA-related activities at the state and local levels, 3) developing PA priority areas and strategies for implementation , and 4) identifying gaps and opportunities for additional partnerships.

MCAH featured work to support breastfeeding and the nutrition, physical activity, and breastfeeding Systems and Environmental Change Toolkit at the Advancing Prevention in the 21st Century: Commitment to Action 2014 Conference.

CHDP is developing and revising education materials for medical providers and low-income families related to obesity prevention and breastfeeding promotion. CHDP continues to provide trainings, consultations and guidance to providers and other public health programs. Local CHDP programs are investigating ways to bridge essential functions of CHDP with MCMC plans.

c. Plan for the Coming Year

MCAH will continue to collaborate with state programs, advocates, experts and local MCAH Directors to prevent children from becoming overweight. Messages and products will be shared with MCAH partners via the MCAH website, email and other mechanisms.

MCAH will continue to collaborate with experts and LHJ MCAH Directors to address MCAH's role in utilizing strategies and tools to advocate for environmental changes to support optimum nutrition, physical activity and breastfeeding. MCAH will continue to promote Food Day to LHJs as an opportunity to inform, engage and empower MCAH populations on matters related to nutrition. Food Day is a nationwide celebration and movement for healthy, affordable and sustainable food.

MCAH will continue to meet four times a year with WIC, Genetic Disease, and SCD to strengthen and coordinate child nutrition and physical activity messaging . MCAH will continue to coordinate with other programs promoting physical activity in CDPH.

MCAH will complete the revisions to the disordered eating section for the AFLP Nutrition and Physical Activity Guidelines. The CDAPP Sweet Success Resource and Training Center will continue to provide webinar trainings and education resources for both health care providers and pregnant women with diabetes.

MCAH is investigating developing alternative nutrition assessment forms for pregnant and postpartum women based on recent evaluation of the CPSP Perinatal Food Group Recall form.

MCAH and SCD will work with OPG to integrate obesity prevention into CDPH programs. MCAH will be on the Planning Committee for the 2015 Childhood Obesity Conference. The Nutrition and Physical Activity Coordinator of MCAH will be the 2014-2015 past-president of ASPHN. Efforts to promote nutrition and physical activity strategies will carry on. MCAH and SCD will continue to work with existing collaboratives, such as Center for Family Health Nutrition Coordination Workgroup, ASPHN, Coordinated Chronic Disease Program and the OPG to implement Nutrition, Physical Activity and Breastfeeding interventions.

MCAH and SCD are exploring ways to ensure that nutrition, physical activity and breastfeeding are adequately covered and marketed in the Affordable Care Act.

Example 5Year Action Plan on obesity and overweight provided to Local Health Jurisdictions include:

- Develop a nutrition and physical activity plan
- Address workplace nutrition and physical activity in the [Public Health Department (PHD)]
- Improve walkability of communities at high risk of obesity
- Implement a weight tracking intervention for pregnant and postpartum women
- Implement physical activity standards in child care centers.

Performance Measure 15

Percentage of women who smoke in the last three months of pregnancy.

a. Last Year's Accomplishments

In 2012, 2.9 % of women aged 15 years and older who had a recent live birth reported smoking in the last trimester of pregnancy. Though the prevalence of smoking during the last trimester of pregnancy is stable as compared to the previous year, the prevalence has shown substantial decline since 1999, when the prevalence was 5.7% among all women in California.

In 2012, Black and White women had the highest rates of smoking in the last trimester of pregnancy (W% and X%, respectively) compared to Hispanic (Y%) and Asian/Pacific Islander (Z%) women. Reported smoking declined in each of these groups since 2008, with the exception of Hispanic women, whose rate did not change.

In California, pregnant women continued to benefit from low smoking rates and a built environment that makes it difficult for one to smoke. The state's adult smoking prevalence has hit a record low of 11.9% in 2010, making California one of only two states to reach the HP 2020 target of reducing the adult smoking prevalence to 12%.

Starting in 2012, California Government Code 7597.1 gives governing bodies of the California State University and each community college district the authority to enforce smoking policies by citation and fine. California Civil Code 1947.5 authorizes a landlord of a residential dwelling unit to prohibit the smoking of tobacco products on the property premises or in a dwelling unit. California Welfare and Institutions Code 4139 dictates that a person who delivers or attempts to deliver tobacco products to a patient at a state hospital where tobacco use is prohibited is guilty of a misdemeanor punishable by a fine of up to $1000 per item. Local jurisdictions are able to regulate smoking more strictly than the state.

Smoking prevention efforts were prominent features of MCAH programs that serve pregnant women and teens. AFLP provided smoking exposure assessment and cessation assistance to pregnant teens. BIH provided health education and health promotion related to smoking cessation in groups and case management for Black pregnant and parenting women. CPSP included smoking cessation as a goal for improving pregnancy outcomes. Handouts, in English and Spanish, educated women about smoking cessation. PHCC provided information, tools and resources on the importance of optimal health before pregnancy, , including anti- smoking messages as part of the CDC preconception health campaign, Show Your Love. Data on non-pregnant women ages 18-44 show that fewer than half discussed smoking or future pregnancy plans during their most recent health care visit. To standardize the content of the preconception well-woman visit, PHCC developed provider screening guidelines.

As part of the local needs assessment data resources, MCAH provided, for the first time, county-level prevalence of smoking in households with children to all LHJs.

CTCP supported statewide and local smoking cessation projects to create effective and innovative tobacco control interventions throughout California. A primary intervention is the

Medi-Cal Incentives to Quit Smoking Project that includes the California Smokers' Helpline to provide intensive tobacco cessation counseling for pregnant women, teens, and adults in multiple languages. Since its inception in July 2012, the Helpline has received over 28,000 calls from Medi-Cal members statewide.

Executive Order B-19-12 established an initiative and a statewide task force to develop a 10-year plan for improving the health of Californians. A priority area is "Health Across the Lifespan" with the goal of eliminating tobacco use and a strategy to affect numerous outcomes, including infant mortality and low birth weight.

CDPH released the "State Health Officer's Report on Tobacco Use and Promotion," highlighting successes (low rates) and problems (sale to minors, smokeless tobacco, marketing to low-income/minorities). A new law enhances enforcement and fees for retailers who sell tobacco products to minors.

b. Current Activities

AFLP/other teen programs, BIH, and CPSP provide smoking interventions which include historical use assessment, education, goal setting, and cessation activities, and referrals for pregnant and parenting women.

The Preconception Health Council of California Public Health Workgroup proposed language First Response to improve their health messaging for women with a negative test result. Among the recommendations were links to resources for smoking cessation. The PHCC is a primary outreach partner for the Smokers' Helpline.

Medi-Cal funds 60% of births and enrollees have high smoking rates. In response, Medi-Cal used ACA funded incentives to encourage enrollees to use the Smokers' Helpline and enroll in free cessation services. Starting in September 2013, 3,000 free nicotine patches and incentives have been provided to Medi-Cal members. MCAH programs disseminate MQIS information to encourage enrollment.

c. Plan for the Coming Year

LHJs will continue smoking cessation activities, including outreach, education, referrals, data collection, and data analysis. Similarly, AFLP/other teen programs, BIH, and CPSP will continue activities to promote smoking cessation and as necessary, update health education and training materials.

The PHCC will continue to provide information, tools and resources--including the preconception and interconception guidelines--to local communities focusing on the importance of achieving optimal health before pregnancy. Messages emphasize refraining from tobacco use and avoiding relapse triggers. A continuing medical education module for interconception care is in development and

will include instructions for developing a follow up plan for women with lifestyle or behavioral issues identified in pregnancy that pose a risk to their health and subsequent pregnancies.

CTCP will continue to support the Smokers' Helpline as well as other projects that facilitate community norm change and support local tobacco control efforts. The PHCC is a primary partner for the MQIS program and Smokers' Helpline and will distribute the new promotional materials highlighting the free nicotine patch incentive offer, the new Helpline web-based referral system, and recommended outreach ideas for health care providers.

MCAH will continue efforts to prevent and reduce tobacco use by pregnant women and women of reproductive age. A stronger focus will be placed on efforts to prevent postpartum smoking relapse in conjunction with SIDS prevention efforts. Coordination with existing programs and initiatives, such as those developed nationally by the CDC and statewide and locally via CTCP, and SIDS prevention efforts can also be explored.

The Medi-Cal expansion and Covered California health exchange enrollment will expand the number of Californians with health insurance coverage. This expanded coverage now includes preventive services without cost sharing, including smoking cessation for adults, with expanded counseling for pregnant women.

At the January 2014 Association of Maternal and Child Health Programs (AMCHP) Conference, HRSA announced that the CoIIN to reduce infant mortality and improve birth outcomes will be implemented in all regions by the end of 201.

At the legislative level, MCAH will collaborate with CTCP to monitor their new local laws and ordinances database. MCAH will explore opportunities to examine smoking trends in relationship to changes in local legislation.

Performance Measure 16

The rate (per 100,000) of suicide deaths among youths aged 15 through 19.

a. Last Year's Accomplishments

The Department of Health Care Services Suicide Prevention Program (SPP) continues to serve as a statewide resource on suicide prevention to further the CA Strategic Plan on Suicide Prevention. In addition, Mental Health Services Act (MHSA) funding is dedicated to statewide suicide prevention programs which are currently being implemented by CalMHSA.

MCAH continues to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer youth at risk for suicide to appropriate assessment and treatment. MCAH collaborates to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery. MCAH

promotes provider screening, education, and referral to treatment and services for adolescence at risk of substance abuse, domestic violence, depression, and stress and encourage LHJs to incorporate mental health and behavioral issues into LHJ activities as they work toward improving the health and well-being of adolescents.

b. Current Activities

The CIPPP contract was cancelled in 2013/14 due to reductions in Title V funding. MCAH will continue to work with CAHC and others to promote best practices in adolescent mental health and to investigate best practices in suicide prevention, domestic violence, depression, and stress. MCAH will continue to work with programs in the local jurisdictions, including the CPSP, AFLP, and BIH programs, to identify and refer adolescents at risk for suicide to appropriate assessment and treatment. MCAH will work to maintain and improve appropriate linkages between other State departments to address systemic barriers and create pathways to service delivery.

Plan for the Coming Year

Due to the reduction of Title V funds there are no planned activities by MCAH. MCAH will promote partnership with other State organizations that are leading suicide prevention efforts in order to promote best practices in local MCAH programs.

Performance Measure 17

Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

a. Last Year's Accomplishments

NPM 17, the percent of Very Low Birth Weight < 1500 grams (VLBW) infants delivered at facilities for high-risk deliveries and neonates, was 77.5 percent in 2012. This was a slight decrease from the 77.7% in 2011, and short of the Healthy People 2020 objective of 83.7%. There is some variation by race/ethnicity in the percent of VLBW infants delivered at facilities for high-risk deliveries and neonates. In 2012, Pacific Islanders had the lowest percentages of these VLBW deliveries at NICU facilities at 61.5 %. African Americans had the highest percent (81.0), followed by Asians (79.8), Hispanic (78.3), and Whites (71.9).

The California figures are based on data from hospitals designated by the CCS program as Regional, Community or Intermediate NICUs. For 2013, there were 132 CCS-approved NICUs in California; however, not all facilities providing care for VLBW infants seek certification by CCS. RPPCs provide planning and coordination to ensure that all high-risk patients are matched with the appropriate level of care. As of FY 2012-2013 RPPC regions were consolidated to 9 regions plus regions for Northern and Southern Kaiser. The RPPCs develop communication networks on many perinatal topics, disseminate education materials including toolkits, assist hospitals with data collection for quality improvement, and provide hospital linkages to CPeTS.

MCAH monitors perinatal outcomes through IPODR (http://www.cdph.ca.gov/data/indicators/Pages/InfantPerinatalOutcomesDataReport.aspx) .The

IPODR website includes an annual county profile report based on California Birth/Death Vital Statistics and Hospital Discharge Data aggregated at the zip code level.
Efforts continue to improve data collected from birth certificates. Since 2004, OVR has collaborated with MCAH working with RPPC leaders to plan and present a statewide series of birth data quality trainings. The interactive presentations include discussions of difficulties in data collection, and explanations of medical terminology including illnesses, complications and procedures of labor and delivery. Fact sheets from the Birth Defects Monitoring Program have been included in the training packets. Awards for excellence and improvement in data collection have been presented to hospitals.

SCD collaborates with CPQCC to monitor outcomes of infants/children, 0-3 years of age in the HRIF Program. This monitoring capability, coupled with perinatal/neonatal CPQCC data elements, allows the assessment of infant outcomes in association with perinatal/neonatal care.

MCAH, in collaboration with CPQCC and CPeTS, continues to implement an electronic data system for tracking of neonatal transports and monitoring of outcomes. This web-based perinatal transport data collection system helps to identify data elements to guide perinatal transport quality improvement.

RPPC, with OVR, provided eight trainings beginning in March 2012, emphasizing the importance of hospital administration, nurses, and birth clerks working collaboratively to accurately report birth data. MCAH is working with OVR to capture more complete information on complications/procedures of pregnancy and complications/procedures of labor and delivery on the birth certificate.

b. Current Activities

RPPC and CPeTS continue matching high-risk patients with the appropriate level of care. RPPCs review birth outcomes data, and transport agreements with hospitals during site visits. All CCS approved NICUs are required to submit data annually, and CPQCC continues to analyze NICU data.
CPeTS maintains a web-based bed availability list where maternity hospitals can obtain information 24 hours a day, 7 days a week for assistance in the transfer coordination of high-risk infant or maternity patients. CPeTS also provides the collection and analysis of perinatal and neonatal transport data for regional planning, outreach program development, and outcome analysis. This information is utilized by RPPC and is reported back to the participating hospitals and to MCAH.

c. Plan for the Coming Year

RPPC and CPeTS continue their work in regional planning and coordination, matching the transport of high-risk patients with the appropriate level of care and assisting hospitals with data collection and quality improvement surrounding patient transfer.

SCD and CPQCC will continue to respond to member questions, analyze data for CCS-approved NICUs, and address outliers and concerns about quality of care. RPPC, with OVR, will continue to present Birth Data Trainings emphasizing collaboration among administration, nurses, and birth clerks to obtain and accurately report birth data. RPPC regional leaders continue to explore

opportunities for nursing staff to work with birth clerks for enhanced birth data reporting in continuing efforts to improve data quality.

Performance Measure 18

Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.

a. Last Year's Accomplishments

The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester was 83.8% in 2012. Asians and Whites met the statewide annual objective for 2012 at 87.5%. Asians and Whites were more likely to receive prenatal care in the first trimester than women who were Hispanic (81.3%), African American (78.7%), Pacific Islander (69.6%)or American Indian (68.9%).

Local MCAH programs identified and monitored trends in access to care, including disparities, conducted targeted outreach, and worked in their local communities to address barriers to early prenatal care. All jurisdictions have a toll-free line that women can call to obtain referrals for pregnancy testing and prenatal care. Most also have websites that provide information on access to prenatal care. In 2012-13, there were 66,482 calls to toll-free lines and there were 369,570 hits to MCAH websites. Local MCAH programs also refer women to low-cost insurance. In 2012-13, MCAH programs made 427,615 referrals to Medicaid and low cost insurance. If women have insurance, they are more likely to obtain early prenatal care. California also has a Presumptive Eligibility program, whereby income- eligible pregnant women are presumed eligible for Medicaid and can immediately start prenatal care. AFLP, BIH, WIC, AIIHI continued to provide case management services and linkages to medical care for their target populations. CPSP provides nutrition, psychosocial and health education services in addition to obstetrical care, and CPSP providers receive incentive payments for women who access care within the first 16 weeks of pregnancy.

PHCC's EveryWomanCalifornia website provides information to consumers about the importance of being healthy before pregnancy, planning for pregnancy and obtaining early prenatal care. Local Perinatal Services Coordinators worked with CPSP providers to implement the PHCC Interconception Care Project Guidelines , which encourage providers to give information and counseling to postpartum clients about healthy behaviors before pregnancy, including planning for optimal pregnancy spacing, obtaining early prenatal care, addressing chronic medical conditions, and avoiding drug, alcohol and tobacco use.

About 40% of all births in California are unintended. [33] The Family PACT Program provides no- cost family planning services to all California residents with incomes at or below 200% FPL. Such services contribute indirectly to timely prenatal care, since women with planned pregnancies seek care earlier.

The AIM program administered by MRMIB provided low-cost coverage for over 7000 pregnant women with incomes from 201-300% of the FPL.

In spite of efforts to increase first trimester prenatal care, the following obstacles remain: delays due to lack of awareness of Medi-Cal Presumptive Eligibility Program, delays due to the Medi-Cal enrollment process, economic downturn leading to more uninsured reproductive age women, insufficient numbers of OB providers in some jurisdictions, and high rates of unintended pregnancy.

b. Current Activities

LHJs continue to monitor access to early prenatal care. CPSP continues to emphasize the importance of interconception planning and early prenatal care. Local MCAH continues its efforts to conduct outreach, provide toll-free information lines, web resources, and refer eligible women for health insurance and early prenatal care. Family PACT continues to make available no-cost family planning services to all California residents with incomes at or below 200% of the FPL. The AIM program continues to make available low-cost health coverage to pregnant women with inadequate coverage and whose incomes are too high for Medi-Cal.

AFLP is increasing capacity of current services by promoting Positive Youth Development (PYD) through reproductive life planning.

BIH, which targets at-risk African American pregnant and parenting women, is implementing the new group intervention model. Both AFLP and BIH continue to encourage and assist clients to receive early prenatal care.

LHJs continue outreach to pregnant women and assist with referrals and enrollment in Medi-Cal and other health plans.

c. Plan for the Coming Year

MCAH will monitor best practices in the LHJs and share these statewide to improve statewide performance. LHJs will continue to monitor access to early prenatal care, conduct targeted outreach to women of childbearing age and pregnant women, provide appropriate linkages and streamline processes for presumptive eligibility to increase access to early prenatal care for pregnant women. LHJs will continue to offer the toll-free line and web information to the MCAH population.

CPSP, AFLP, WIC, BIH, and AIIHI will continue to provide case management services and linkages to medical care for their target populations and educate clients regarding the importance of receiving early prenatal care for future pregnancies.

Local CPSP coordinators will continue provider recruitment and work with providers to improve interconception education during the postpartum period. MCAH and LHJs undertake

these activities to ensure the availability and effectiveness of CPSP services, even in this era of budget constraints, and to achieve improvements in first trimester entry into prenatal care. MCAH will work to improve data on beneficiaries, paid claims, birth outcomes, and hospital discharge to develop baseline data on the efficacy of CPSP services. MCAH will continue to work closely with MCMC to improve the timeliness and quality of OB services to Medi-Cal-eligible pregnant women.

AFLP will continue to implement the Positive Youth Development component into existing services.

BIH will continue to implement the new group intervention, as well as complementary case management, in order to improve the health and social conditions for African-American women and their families.

C. State Performance Measures

State Performance Measure 1

The percent of children birth to 21 years enrolled in the CCS program who have all their health care provided by and coordinated by one health care system.

a. Last Year's Accomplishments

After all implementation requirements were met, the first 1115 Waiver Model, Medi-Cal Managed Care, began April 1, 2013 in San Mateo County. Initial steps to evaluate the program have begun.

b. Current Activities

The 1115 Demonstration Waiver Project pilot contract with Health Plan of San Mateo identifies a Medical Home for members as the foundation of an integrated and coordinated health care delivery system.

Monitoring is ongoing with the first CCS 1115 Waiver Model, Medi-Cal Managed care that began April 1, 2013 in San Mateo County. The health plan has begun providing data which the state is analyzing to ensure family centered care, attention to satisfaction of patient, family and providers, and appropriate healthcare access.

c. Plan for the Coming Year

The 1115 Evaluation Oversight Committee will include a "dashboard" for rapid determination of any areas which require more attention, and extensive family/providers satisfaction to access, integration of care, and identify barriers to reform. A family survey is being developed for all counties, including pilot counties.

State Performance Measure 2

(no narrative is associated with this section since state performance 2 was discontinued)

State Performance Measure 3

The percent of families of children, birth to 21 years enrolled in the CCS program, randomly selected by region who complete an annual satisfaction survey.

a. Last Year's Accomplishments

Family surveys have been implemented in the MTP program, as part of the alternative therapy model.

b. Current Activities

A statewide family satisfaction survey is being developed based on survey done by counties, and with Title V stakeholder input.

c. Plan for the Coming Year

CCS Family survey currently in planning stages. Plan is to accept surveys online, and via phone administered by local CCS staff.

State Performance Measure 4

Percent of women with a recent live birth who reported binge drinking during the three months prior to pregnancy.

a. Last Year's Accomplishments

SPM 04 is the percent of women with a recent live birth that reported binge drinking during the three months prior to pregnancy.

FASD describes the range of effects in individuals whose mothers used alcohol during pregnancy, including physical, cognitive, behavioral and learning difficulties with lifelong implications.

MCAH promotes preconception health, of which alcohol use prevention in women of reproductive age is a key feature. MCAH participates in PHCC, providing information, tools and resources for communities on the importance of optimal health for women before pregnancy. PHCC developed educational materials informing women of the risk of unintended pregnancy associated with alcohol use. The PHCC website has valuable information on perinatal substance use prevention.

PHCC continued to monitor its website, designed for mixed use by consumers and health professionals. The website connects people working in preconception health and features links to tools and resources related to alcohol use prevention for men, women and teenagers.

MCAH participates in the FASD Task Force comprised of state/local agency representatives. An FASD Task Force website has been developed to complement its work on increasing legislators'

awareness of FASD. The FASD Task Force continues to work on bringing more prominence to the annual celebration of FASD Awareness Day in September. It partnered with DSS to produce an educational brochure on alcohol use prevention targeted to youth.

The CA Preconception Peer Educators (PPE) Program is a local implementation of the Federal Office of Minority Health Program. PPE teaches college students about preconception health risks and trains them to become campus and community ambassadors. Given the popularity of binge drinking among teenagers and college students, a key focus of PPE is alcohol. The PPE curriculum links high-risk drinking to risks relevant to women who are not actively planning a pregnancy including sexual assault, domestic violence, trauma, homicide, criminal prosecution, unintended pregnancy, risk taking behavior as well as traditional focus on FASD. The PPE program collaborated with the CDC Preconception Health Show Your Love campaign, which has separate targeted alcohol-related messages about abstinence for those planning a pregnancy and avoiding binge drinking and using contraception for those not planning a pregnancy.

b. Current Activities

MCAH works to improve birth outcomes for women at risk for alcohol abuse through screening and referral for treatment services. Community-based prevention programs such as AFLP, BIH and CPSP identify at-risk mothers and refer them for treatment services.

LHJs continue to develop and strengthen coalitions with public/private agencies and providers to assess women at risk and develop appropriate referrals to resources including the statewide FASD Taskforce. Many are working to develop coordinated and integrated systems of care to address issues of perinatal substance use.

c. Plan for the Coming Year

LHJs will continue to work on developing and strengthening coalitions with public/private agencies and healthcare providers to determine how best to identify women at risk and how to develop appropriate referral sources. LHJs will continue to develop and implement coordinated and integrated systems of care to address perinatal substance use prevention. MCAH will continue to participate in the FASD Task Force and will continue its efforts on preconception health education and promotion, including augmenting and monitoring its preconception health website. The Federal Office of Minority Health established an Advisory Board to Preconception Peer Educators at California Community Colleges and Universities will partner with LHJs and local organizations to plan campus and community outreach campaigns and events to promote harm reduction strategies to reduce preconception alcohol exposure and prenatal alcohol exposure. These outreach strategies will include social media.

MCAH will continue ongoing quality improvement and education efforts to learn about emerging best practices for reducing binge drinking. Because California has unique alcohol consumption patterns arising from the popularity and cultural significance of locally produced wine, MCAH will continue to explore ways to find culturally appropriate strategies to reduce heavy

consumption patterns and prevent illegal consumption by minors. Among the strategies will be to engage the newly acquired TPPs, I&E and CA PREP, and strengthen their ability to include substance abuse prevention as a teen pregnancy prevention strategy.

State Performance Measure 5

Percent of cesarean births among low risk women giving birth for the first time.

a. Last Year's Accomplishments

In 2012, C-section births among low-risk women giving birth for the first time were at 26.7%. To explore the multifaceted contributors to maternal morbidity and develop valid indicators to provide surveillance for maternal health statewide, MCAH funded the MQI with UCLA. MQI and CMQCC provided expertise and support for development of new obstetrical measures for the National Quality Forum which were then incorporated by the Joint Commission.

As a result of surveillance efforts, CMQCC developed and disseminated a toolkit to reduce non-medically indicated labor induction and cesarean section prior to 39 weeks gestational age. MCAH has also collaborated with MOD to publish and disseminate the toolkit throughout the state. The toolkit provides guidelines to hospitals and materials for patient education. The toolkit is now in use nationwide and has been credited with reductions in elective delivery in six states.. CMQCC released a toolkit to improve the healthcare response to preeclampsia—a contributor to cesarean delivery.

MCAH previously funded a Local Assistance for Maternal Health (LAMH) project in San Bernardino to reduce non-medically indicated induction of labor by educating the community about labor induction and promoting best practices among clinicians and providers. Their efforts included labor induction guidelines and recommendations for local area hospitals to follow when scheduling labor inductions; patient consent document to inform patients of options; and, an Advisory Council comprised of public and private organizations Fourteen hospitals in San Bernardino participate in the project and are regularly involved in webinars and data sharing. Recently, San Bernardino County LAMH outcome data were analyzed and reported. Because the data collection strategy was implemented in concert with departmental policies and community education, it impacted practice patterns substantially. MQI published a manuscript in the Journal of Obstetric, Gynecologic and Neonatal Nursing which compared three methods of tracking elective delivery: electronic medical record data, hospital discharge data, and data from the LAMH project. The findings were that the San Bernardino LAMH quality improvement data collection and reporting project had advantages for monitoring elective delivery as compared with the other methods. Reduced resources has resulted in discontinuing the project but the model is available for replication.

b. Current Activities

The CMQCC is developing a data center to provide timely information on elective deliveries and induction among high and low risk patients.

Los Angeles County is conducting a county-wide campaign to reduce cesarean deliveries.

CMQCC is addressing maternity care and birth data quality issues with RRPC

MCAH accepted the Association of State and Territorial Health Organizations/March of Dimes Preterm Birth Challenge. California met the ASTHO challenge by reducing prematurity to 9.6 percent.

The PHCC and MCAH Preconception Health and Nutrition and Physical Activity Initiatives conducted activities to ensure women are entering pregnancy with fewer risks that may increase the likelihood of cesarean delivery. (See Major State Initiatives).

MQI produced an internal report on the composite morbidity indicator which will be used in the maternal health report published next year. A preliminary draft of the maternal health report—addressing contributors to morbidity—is being drafted for internal review.

c. Plan for the Coming Year

MQI and MCAH will externally publish a maternal health report to increase our understanding of maternal morbidity in California which will include an overview of cesarean delivery. MQI will also continue to develop a composite maternal and infant health indicator and begin exploring the public payer (Medi-Cal) associated costs of morbidity using data from 2007-2009.

MQI is beginning to develop a separate exploratory analysis of the relationship between rising prevalence of cesarean delivery and maternal morbidity. This will involve estimating the contribution of pre-existing (preconception), pregnancy-related, and obstetric maternal morbidity to Nulliparous, Term, Singleton, and Vortex (NTSV) cesarean deliveries and to also estimate the contribution of NTSV cesarean delivery to postpartum maternal readmission rates, postpartum morbidity, and the severity of morbidity. Efforts will also be made to explore cumulative cesarean-related morbidity risk as parity increases.

CMQCC will continue to provide technical assistance to local and regional maternal health efforts related to cesarean delivery.

MCAH is preparing to participate in the HRSA-initiated Collaborative Improvement and Innovative Network (CoIIN) to support the adoption of collaborative learning and quality improvement principles and practices to reduce infant mortality and improve birth outcomes. One of the state- identified priorities is reducing elective deliveries <39 weeks.

State Performance Measure 6

Percent of women of reproductive age who are obese.

Last Year's Accomplishments

Between 2000 and 2010 there was a 27% increase in obesity among women of reproductive age. In 2012, the prevalence of obesity in this population was 21.6%, up slightly from 21.3% in 2011. Hispanic (29.3%) and Black (27.1%) women were more likely to be obese than White (17.2%) women.

To reduce the burden of obesity among women of reproductive age, MCAH promoted obesity reduction and healthy strategies to achieve optimal preconception weight, prenatal weight gain, and breastfeeding.

MCAH provided input for the CDC preconception health campaign, Show Your Love, which emphasizes the importance of healthy weight before pregnancy.

MCAH and the PHCC launched the CDC Show Your Love campaign on Valentine's Day; resources featured healthy weight messages for women who are planning a pregnancy in the next two years and those who are not. In partnership with the campaign, the PHCC posts about healthy weight using social media.

San Joaquin Valley trained PPEs who are now training their peers and community members. Knowledge about pre-pregnancy weight was high initially, but overall knowledge improved.

To address the need for gestational diabetes resources in Asian languages, the ICPC gestational diabetes handout was translated into Vietnamese and posted online. It contains healthy weight tips to help prevent type 2 diabetes and reduce risks in a subsequent pregnancy.

Many women of reproductive age live in environments not supportive of healthy weight, so MCAH developed an online toolkit to provide nutrition, physical activity and breastfeeding resources for local MCAH Programs to address the built environment. It includes a sample PowerPoint and webinar featuring Dr. Richard Jackson and local MCAH Directors

Adolescent cookbooks were printed in English and Spanish and distributed to adolescent programs to encourage healthy eating and physical activity.

To address pregnancy weight gain, grids for twin pregnancies were developed. MyPlate for Gestational Diabetes was created in English and Spanish; it includes a food guide and goal setting tips. To learn more, see NPM 14. MyPlate for Moms was finalized and encourages pregnant/breastfeeding women to eat healthy meals, with limited sugar, solid fats and salt.

The physical activity section of the AFLP Nutrition and Physical Activity Guidelines was revised. MCAH continued existing collaborations and began collaborating with the Coordinated Chronic Disease Program.

Current Activities

MCAH is updating CDAPP, CPSP, BIH, and AFLP nutrition and physical activity guidelines. MCAH programs continue to prioritize optimal nutrition and physical activity as important interventions to reduce obesity in women of childbearing age.

MCAH continues to focus on a life course perspective for addressing obesity since childhood, preconception, pregnancy, interconception, and infant feeding impact adult obesity.

MCAH collaborates with WIC to promote healthy weight among women of reproductive age by promoting appropriate gestational weight gain, breastfeeding, and postpartum weight loss.

MCAH featured the Systems and Environmental Change Toolkit to support optimal nutrition, physical activity, and breastfeeding through fostering partnerships between local health jurisdiction's MCAH Programs at the Advancing Prevention in the 21st Century: Commitment to Action 2014 Conference to release the CA Wellness Plan.

MCAH participates in a Physical Activity (PA) Collaborative Impact Planning Group. In the sessions CDPH physical activity staff are 1) sharing about current/future CDPH PA projects, programs, and interventions, 2) identifying where there are opportunities to integrate our PA-related activities at state and local levels, 3) developing PA priority areas and strategies for implementation , and 4) identifying gaps and opportunities for additional partnerships.

Plan for the Coming Year

MCAH will continue to collaborate with state programs and agencies, experts and local MCAH directors to reduce overweight and obesity among women of childbearing age.

MCAH programs will offer counseling, such as guidance on dietary intake and physical activity, which is tailored to client circumstances/stage of change.

MCAH will investigate leveraging existing campaigns to include preconception messaging, such as the 50 million pound challenge sponsored by State Farm, Let's Move Campaign, Black Girls Run, Girl Trek, and the President's Council on Physical Fitness. Also, MCAH will investigate building linkages with existing nutrition resources, such as community garden programs, farmer's markets and diet support programs. Feasibility of new campaigns, such as a "Biggest Loser" spin-off geared toward women of reproductive age with incentives and rewards coming from community and corporate partners with a vested interest in promoting weight loss will be considered. MCAH will also consider expanding partnerships with community colleges and universities throughout the state.

Per recommendations by the IOM's Committee to Reexamine IOM Pregnancy Weight Guidelines (2009), MCAH will continue to conduct routine surveillance of pre-pregnancy BMI, weight gain during pregnancy and postpartum weight retention and report the results by age, racial/ethnic group, and socioeconomic status to inform local initiatives to promote healthy weight.

MCAH will continue to inform women of the importance of conceiving at a normal BMI as part of the preconception initiative, encourage women to limit their weight gain during pregnancy based on the revised IOM guidelines and make the most current resources on pregnancy weight gain available on the MCAH website.

MCAH will help to maximize use by women of Affordable Care Act provisions for well-woman care and obesity screening/counseling for all adults by partnering with Covered California and Medi-Cal. MCAH will publicize resources that support healthy weight to healthcare providers and public health professionals and encourage their use during well-woman and prenatal care. Among these resources will be the Interconception Module which will provide continuing medical education credits on the Before, Between and Beyond website.

MCAH will explore new media strategies to popularize preconception health to a younger and more technologically-advanced audience. MCAH plans to explore the development of mobile applications or adaptation/use of the GABBY™ interactive system that provides personalized electronic preconception health education and follow-up. Pilot testing for the GABBY™ system is scheduled to conclude in early 2014.

State Performance Measure 7

The percent of women whose live birth occurred less than 24 months after a prior birth.

a. Last Year's Accomplishments

Between 2009 and 2010, SPM 7 decreased by 5% from 12.9% to 12.3%, and remained unchanged in 2011. By 2012, SPM 7 was 12.0% representing a 2% decrease overall from

2011. Of the four race/ethnic groups with the largest birthing population in 2012. African American women were most likely to have a live birth less than 24 months after a prior birth (13.8%), followed by Hispanics and Whites each at12.2% and Asians (9.8%).

Preconception and interconception care is a priority for the MCAH Program. The Preconception Health Initiative (PHI) aims to improve the health of women prior to pregnancy to improve birth outcomes and reduce disparities in maternal and infant morbidity and mortality. A critical part of PHI is to ensure at least 18 months (or restoration of health and functioning) between pregnancies--especially among women with previous poor birth outcomes--to encourage healthy child development and to reduce health risks for mothers and subsequent infants. To reduce unintended pregnancy and improve birth spacing, MCAH and the Office of Family Planning (OFP) supported programs that help women and teens understand the importance of pregnancy timing, decrease risky health behaviors and increase access to and appropriate use of contraceptives.

PHCC disseminated messages about the importance of reproductive life planning (RLP), planned pregnancies, birth spacing and preconception care through stakeholders to local communities statewide. The website, www.everywomancalifornia.org, has resources for consumers and providers. In June 2012, the website was redesigned to integrate RLP into site navigation. Spanish-language webpages were developed to be more visually-appealing.

The PHCC preconception care guidelines are promoted to provide clinical guidance on the well-woman visit covered as preventive care (no cost-sharing) under ACA.

PHCC disseminates and conducts trainings on the Interconception Care Project of California for health care and public health professionals.

MCAH provides trainings on preconception and interconception health, including to the National WIC Association, and shares the clinical and public health tools available.

MCAH works with LHJs to promote reproductive life planning and adequate birth spacing through the PPE program. Post-secondary students trained in preconception health are able to support community outreach initiatives to address preconception and interconception health.

Family PACT, I&E, PREP and AFLP continue teen pregnancy prevention efforts. AFLP began the Positive Youth Development intervention centered on RLP to empower clients, encourage goal setting and reduce repeat teen births. The new BIH model that includes goal setting and RLP was implemented at all sites.

The CDAPP Sweet Success Resource Center website went live and guidance on preconception health and optimal birth spacing for women with diabetes is posted.

MCAH promotes the CDC preconception health campaign, Show Your Love, which includes focus on RLP. It includes videos and checklists with messaging tailored to one's plans to have a baby.

b. Current Activities

MCAH focuses on four priority areas: folic acid use, linkage to medical home, family planning and healthy relationships and developed the social media toolkit for young adults to help Preconception Peer Educators, local partners, and other health agencies target year-long messages to young men and women in the four areas.

MCAH is developing the Interconception Care Module, which will emphasize contraceptive counseling and appropriate birth spacing, especially for women with previous preterm/low birth weight infants and those with pregnancy or obstetrical complications.

PHCC collaborated with MOD to propose revised language to First Response® for inclusion in the home pregnancy test kit. The proposed information emphasizes available birth control options, links to bedsider.org and the CDC Show Your Love Healthier-Me resources to help with reproductive life planning and birth spacing.

MCAH implemented the Show Your Love campaign in CA. Pill boxes for birth control and folic acid with the Show Your Love logo were procured through local funding. Condom cases with the words "Love the Glove" were provided to encourage condom use among adolescents and young adults.

The MCAH LHJ scope of work has a sample objective to collaborate with RPPC and local hospitals on discharge counseling for women with pregnancy complications providing an opportunity to reinforce birth spacing messages for high risk women with postpartum readmissions.

c. Plan for the Coming Year

The MCAH Program will continue to strengthen and expand its interconception and reproductive life planning initiatives toward the aim of ensuring adequate birth spacing and reducing teen births.

Adolescent programs will continue to revisit life planning tools and explore the best strategies for reducing teen pregnancy and repeat births to teens.

Programs that target pregnant women will provide up-to-date messaging about birth spacing and overall preconception/interconception health.

The California Home Visiting Program will promote appropriate pregnancy spacing with contraceptive education, counseling, and referral to clinical services beginning in the final trimester of pregnancy and extending throughout the postpartum period.

The CFHC will continue its efforts to expand its reproductive life planning demonstration project to all clients of Title X-funded clinics by 2015.

MCAH will continue to educate at-risk groups about contraception and birth spacing and will explore the best strategies to effectively engage younger and electronically-inclined populations, empowering them to make healthy reproductive decisions. The social media toolkit will be pilot tested and revised for full-scale implementation.

The PHCC plans to develop clinical scripts and protocols for negative pregnancy test and to pilot test an in-store promotion in Sonoma County. The PHCC also plans to reach out to Pharmacist Associations. Because many women taking pregnancy tests receive a negative result, this is an important opportunity to provide contraception messages to reduce unintended pregnancy among women who do not want to be pregnant and are at risk; specifically for those who gave birth in the previous 24 months.

MCAH will continue to share national resources, including the preconception campaign materials developed by the CDC and PPE materials provided by the federal Office of Minority Health.

The ACA offers opportunities to help prevent unintended or mistimed pregnancies by improving health care coverage for women through Covered California and private health plans. MCAH will help raise awareness about ACA preventive care provisions that require new health plans to provide FDA-approved contraception without cost-sharing.

MCAH will continue to publicize the preconception and ICPC guidelines as clinical tools available to providers who connect with women of reproductive age, either in their well-women visit or postpartum visit (for women who just had a baby). These clinical visits are critical opportunities to help women prevent or delay pregnancy until they are ready. To ensure providers have adequate education regarding interconception health and birth spacing, an online module with continuing medical education credits is being developed for self-paced instruction to coincide with the ICPC.

State Performance Measure 8

The percent of 9th grade students reporting a high level of school connectedness.

a. Last Year's Accomplishments:

MCAH supports school connectedness through a positive youth development in three ways: 1) the Adolescent Family Life Program (AFLP); 2) CAHC, a statewide coalition of individuals and organizations, both public and private, whose main goal is to support adolescent health in California through trainings, data analysis, education, and TA to MCAH and to local MCAH programs; and, 3) ASHWG, comprised of program managers from the CDPH, including Office of AIDS, STD Control Branch, Office of Family Planning, and Maternal, Child and Adolescent

Health), CDE, and key CBOs, including CAHC and the State Title X Administrator for California, the CFHC.

AFLP continues to support clients to graduate from high school through its strength-based positive youth development intervention. CAHC provides guidance and training in the use of a positive youth development framework that supports linking clients to education. ASHWG has developed indicators for positive youth development; by achieving these indicators, it is believed that providers will assist students in meeting education goals.

In June 2013 MCAH received a the U.S. Department of Health and Human Services, Office of Adolescent Health (OAH) grant to continue and enhance the existing activities begun under a previous OAH grant. This funding would continue the AFLP PYD case management with integrated life planning intervention for an additional 4 years in order to implement a standardized evidence-informed program strategy.

b. Current Activities

MCAH is continuing to implement AFLP and apply the best practices learned from the AFLP PYD efforts into the overall statewide AFLP program. Through a second OAH grant opportunity, MCAH is developing an outcome evaluation for the next 3 years in order to develop an evidence-informed intervention for AFLP in order to improve adolescent school and health outcomes. MCAH will also continue its work with CAHC to support local MCAH programs as they implement adolescent health measures.

c. **Plan for the Coming Year**

MCAH will continue to implement AFLP and apply the best practices learned from the AFLP PYD efforts into the overall statewide AFLP program. MCAH will use the results of the AFLP PYD process evaluation to develop an outcome evaluation plan that will lead to an evidence-informed intervention for AFLP in order to improve adolescent school and health outcomes. MCAH will also continue its work with CAHC to support local MCAH programs as they implement adolescent health measures.

State Performance Measure 9

Infant mortality rate among low-income women

a. Last Year's Accomplishments

The low income infant mortality rate reflects deaths among infants born to women for whom Medi- Cal was the principal source of payment for prenatal care or delivery.

Sixteen LHJs implement FIMR programs. In Contra Costa, preconception/ interconception education has been integrated into the maternal interview, which is an essential component in the spectrum of case management and family support services offered to clients following a fetal or infant death. Given its size and large number of birthing hospitals, L.A. County uses a survey tool

(L.A. Health Overview of a Pregnancy Event) to conduct FIMR. The survey questions are designed to focus on maternal behaviors and health system variables that can be addressed by public health interventions.

All MCAH LHJs conduct outreach to encourage pregnant women to seek early prenatal care through programs such as Prenatal Care Guidance. Many LHJs integrate preconception and interconception messaging into their services as a strategy to prevent poor birth outcomes such as infant mortality.

Various MCAH programs and initiatives, including CPSP, AFLP, BIH, RPPC and PHHI, work on improving infant health and birth outcomes and enroll mostly low-income women. CPSP aims to decrease the incidence of low birth weight (LBW<2500 grams) infants by providing at-risk women with comprehensive services including prenatal care, health education, nutrition and psychosocial support. Over 1,500 Medi-Cal obstetrical practitioners provide CPSP services, serving approximately 165,000 women annually. A primary goal of AFLP is to improve birth outcomes for babies born to adolescent clients, many of whom receive Medi-Cal services. AFLP assists pregnant adolescents to access prenatal and other necessary health care early in pregnancy, provides nutrition counseling, and works with teens to eliminate behaviors contributing to poor birth outcomes. African American infants are more than twice as likely as infants of other racial/ethnic groups to be born LBW in California. BIH identifies pregnant and parenting African American women at risk for poor birth outcomes and assists them in accessing and maintaining appropriate healthcare and support services.

MCAH and SCD collaborate with CPQCC on performance improvement in perinatal and neonatal outcomes. CPQCC has 132 member hospitals, accounting for over 90 percent of newborns requiring critical care. RPPC provides consultation to delivery hospitals and supports implementation of clinical quality improvement strategies by collaborating with maternal and neonatal providers to address evidence-based quality improvement projects and improve risk-appropriate care.

L.A. County participated in the Partnership to Eliminate Disparities in Infant Mortality, an 18-month collaborative project (September 2008-February 2010) sponsored by the Association of Maternal Child Health Programs, CityMatCH and National Healthy Start Association, which provided tools to address infant mortality disparities. The L.A. County and Action Learning Collaborative (LAC ALC) aims to increase capacity at the community, State, and local levels to address the impact of racism on birth outcomes and infant health. Its website provides information on resources and best practices relating to infant mortality and undoing racism. In December 2011, the ALC held a successful Racial Justice Leadership Institute training on undoing racism for collaborative members' staff, with a total of 42 participants.

MCAH participates in PHCC, providing information, tools and resources to local communities on achieving optimal health for women prior to pregnancy. MCAH and SCD collaborated with MOD on its Prematurity Campaign which aims to invest in research, education and community programs to identify causes of prematurity and develop strategies to improve birth outcomes. A

statewide effort to reduce elective deliveries of less than 39 weeks gestational age is ongoing throughout the state through efforts with multiple stakeholders: MOD, ACOG, the California Hospital Association, and CMQCC with encouragement from RPPC.

California accepted the Association of State and Territorial Officials (ASTHO) Healthy Babies Challenge in May 2012. Its specific objective is to reduce prematurity rates by 8% by the year 2014, using 2009 data as baseline. ASTHO is partnering with MOD on implementing this challenge nationally and further promoting MOD's Prematurity Campaign. MCAH included prematurity prevention specific objectives in the MCAH Scope of Work for LHJs and is working with key stakeholders and partners in addressing this challenge.

b. Current Activities

MCAH participates in the ASTHO Healthy Babies Challenge, which aims to prevent premature births and reduce infant mortality. In partnership with MOD, ASTHO challenged states to reduce their percent of premature births by 8% by 2014, using 2009 data as baseline. The percent of premature births in California was 10.4% in 2009, decreasing to 9.6% in 2012, thus achieving the target 2014 goal in 2012. This accomplishment earned California the "A" grade in the MOD 2013 Premature Birth Report Card.

LHJs and various MCAH programs and initiatives, including CPSP, AFLP, BIH, RPPC and PHHI, continue their work on improving infant health and birth outcomes. The newly revised BIH intervention provides a 20- session group intervention (10 prenatal and 10 postpartum) with complementary case management that provides support to empower clients to make healthier choices for their babies. Case management ensures linkage to prenatal services. L.A. maintains the LAC ALC website to provide information on resources and best practices relating to infant mortality and undoing racism. With its multidisciplinary local partners, LAC ALC continues its mission of increasing capacity at the local and state levels to address the impact of racism on birth outcomes and infant health.

MCAH, CMQCC and MOD continue to promote the Elimination of Non-medically Indicated (Elective) Deliveries Before 39 Weeks Gestational Age Toolkit, which facilitates improvements in maternity practice care.

c. **Plan for the Coming Year**

LHJs continue to perform outreach, client education and case-finding functions, including a toll-free telephone information service and targeted activities designed to assist women in receiving early and continuous prenatal care. Programs also provide critical social support services, case management and client follow-up.

L.A. County continues its ALC work. The ALC plans to hold more health disparities training workshops for healthcare providers as part of its mission to increase local capacity to address the impact of racism on birth outcomes and infant health.

MCAH and SCD continue to collaborate with MOD and ASTHO on the Healthy Babies Challenge/Prematurity Campaign. The MCAH Scope of Work for LHJs will continue to include prematurity prevention specific objectives.

CMQCC and RPPC continue to provide technical assistance to hospitals and LHJs who wish to reduce elective deliveries for pregnancies less than 39 weeks gestation.

State Performance Measure 10

The percent of CCS clients who have a designated primary care physician and/or a specialist physician who provides a medical home,

a. Last Year's Accomplishments

This is a new performance measure. In 2008, the current set of Performance measures for CCS were developed, which included that counties should indicate whether each CCS client has an identified medical home. Through 2013, a state CCS workgroup updated and strengthened the CCS annual performance measure for medical home.

In addition, state CCS staff developed case management procedures to identify each CCS client's primary care medical home provider and enter into the CMS Net Registration database.

b. Current Activities

State CCS continues to develop a medical home policy which supports the CCS program's annual performance measure for medical home.

Obtain detailed reports from counties on number/percent of CCS children with 'medical home' by physician or nurse practitioner provider in a usual place of care.

Meet with county CCS administrators to review Medical Home performance measure, its definition, how to consistently apply Medical Home definition in the SCD performance measure reporting of a primary care medical home provider in a usual place of care.

Collaboration continues with CRISS on the development of CCS medical homes policy.

The Medi-Cal Managed Care model of the CCS 1115 Waiver Program pilot began April 2013. Medical Home is incorporated into the comprehensive health care delivery system and is one of the areas of performance evaluation for the project

c. **Plan for the Coming Year**

CCS will continue to work with the counties to ensure each CCS client has access to a medical home provider in a usual place of care.

1. CCS will have a CCS Medical Home Workgroup to assess how the medical home concept is applied differently across counties with different systems of care and different regions.

2. Develop and issue policy letter to request that County CCS offices identify only primary care providers, not clinics, as designated Medical Homes.

3. State CCS will continue to monitor the counties compliance to identify and document each CCS enrolled client's primary care medical home provider.

4. The Medical Managed Care model of the CCS 1115 Waiver Program pilot continues to provide Medical Home into the comprehensive health care delivery system and the performance data continues to be analyzed.

5. For counties not in an 1115 Waiver Pilot Project, CCS will continue to monitor the number of CCS clients with a designated Medical Home.

D. Select Health Status Indicators

Health Status Indicator 03A

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.

Narrative:
Funding for technical support activities provided by San Diego State University's Center for Injury Prevention Policy and Practice (CIPP) was eliminated due to cuts in Title V funding.

Health Status Indicator 11

Demographics (Poverty Levels) Percent of the State population at various levels of the federal poverty level. (Demographics)

Narrative:

The official poverty measure (OPM) does not account for geographic variation in cost of living, government policies and assistance, medical care, childcare, and transportation. OPM was adopted in 1963 defined as the cost of a minimum budget for nutritionally adequate food multiplied by three; the resulting value has been adjusted annually using the Consumer Price Index to account for inflation. Since its adoption, the OPM has been criticized for its inconsistency in the way it accounted for household costs and resources. On the fundamental level, the base food costs and multiplier used to generate the original OPM thresholds no longer reflect the typical amount or proportion of income that modern households spend on food. Concerns with the OPM have been regularly identified because it does not account for geographic variation in cost of living, government tax and benefit policies that alter resources available, family receipt of government assistance such as food stamps, and increases in life costs such as medical care, childcare, and transportation and the reduction in family size over time. Congress has been concerned by the measure's limitations and in 1990 a Congressional

Appropriation resulted in an independent study of the concepts, measurement methods, and information needed for a poverty measure. The National Academy of Sciences established the Panel on Poverty and Family Assistance and in 1995 published their findings that the measure needs to better reflect social and economic realities, and government policies. [34] Further refinements was completed in 2004. The Census Bureau released experimental poverty measures in 1999 and 2001; and in 2010, the Obama administration directed the Census Bureau and the Bureau of Labor Statistics to produce a Supplemental Poverty Measure (SPM) that largely follows the methods recommended by the National Academy of Sciences. The Interagency Technical Working Group on Developing a SPM was to begin publishing a SPM that could get released alongside the official annual poverty measure. The resulting SPM represents a dollar amount spent on basic goods (food, shelter, clothing), family types, geographic differences in housing, and income including receipt of cash-equivalent in-kind government assistance used to meet basic needs. SPM subtracts from family resources money spent on federal and state income taxes and federal payroll taxes as non-discretionary expenses, while adding to family resources money received through refundable tax credits. SPM more accurately picture of who is still poor after considering the effects of most of the existing government policies designed to prevent or ameliorate poverty. A comparison of the SPM and OPM for 2009 – 2011 showed an additional 2.7 million in poverty in California with a net over-all increase of 2.5 million in poverty nationally; California alone accounted for the nationwide increase.